Connecticut Partnership Plan
Add/Term/Change Form

Anthem Group Number:	
Cigna Branch Code:	

*For HR Use Only

New Enrollee(s):	
Term Subscriber:	
Term Dependent(s):	
Change Information:	

*For HR Use Only

EMPLOYER NAME:	
EMPLOYEE NAME: (Last, First)	
EMPLOYEE STREET ADDRESS:	
CITY, STATE & ZIP:	
EMPLOYEE PHONE NUMBER & EMAIL:	

*Note: Phone number is vitally important. Without a valid phone number, we are unable to contact members regarding clinical programs or HEP programs.

EFFECTIVE DATE:	

COVERAGE ELECTIONS:	Medical/RX	Dental
Employee Only		
Employee + 1		
Family		
Waiver		
COBRA		

	NAME Last, First	DOB	Social Security Number	Gender	Add / Term
EMPLOYEE					Add / Term
DEPENDENT (Spouse)					Add / Term
DEPENDENT (Child)					Add / Term
DEPENDENT (Child)					Add / Term
DEPENDENT (Child)					Add / Term
DEPENDENT (Child)					Add / Term
DEPENDENT (Child)					Add / Term
DEPENDENT (Child)					Add / Term

MEDICARE INFORMATION:
Member Name: _____
Medicare ID Number: _____
Part A Effective Date: _____
Part B Effective Date: _____

EMPLOYMENT INFORMATION:
- Employment Status: _____
(Example: FT, PT, Disabled, Retired)
- Number of Hours worked per week: _____
- Hire Date: _____

EMPLOYEE SIGNATURE: _____ DATE: _____

By signing this CT Partnership Plan enrollment form, I agree, on behalf of myself and all enrolled dependents, to participate in the Health Enhancement Program (HEP). I understand that I will lose the financial incentives of the HEP program if I or any of my enrolled dependents fails to comply with the requirements of the HEP program.

Anthem

OFFICE of the STATE COMPTROLLER