CBIA HEALTH CONNECTIONS
THE POWER OF CHOICE

Enrollment/Change Form

Reset Form

1. EMPLOYER NAME: iTech Solutions, Inc. **Pending Paperwork Number** N/A

Employer Group Number: 9060058 **Division Name:** N/A

Enrollment	**Change** (indicate reason) Effective Date _____	**Termination of Coverage**	
☐ New Group	☐ Add Dependent	Effective Date _____	
☐ New Employee	☐ Marriage/Civil Union ☐ Birth/Adoption		
☐ Existing Employee; Newly Eligible	☐ Loss of other coverage (attach Proof of Loss)	☐ Dropping coverage. Cancel only the following coverages:	
☐ Existing Employee; SPECIAL ENROLLMENT	☐ Remove Dependents	☐ Medical	
☐ Rehired/Reinstatement of Coverage	☐ Other		
☐ Open Enrollment	☐ Open enrollment		

2. Employee information—please print clearly and complete the entire form

Employee Name		Email	# of hours worked per week: _____
Street Address	Apt #	Home Telephone / Work Telephone	Are you: ☐ Actively at work ☐ COBRA ☐ Retired
		Employee date Hire/Rehire/Retirement ☐ ☐ ☐ / Part-time to Full-time Employment Date _____	Do you or any dependents have Medicare? ☐ Yes ☐ No
City, State, ZIP		Marital status ☐ Single ☐ Married / Effective Date:	Do you or any dependents have Medicare Part A ___ Part B ___ Both ___

3. LIST YOURSELF AND ALL ELIGIBLE DEPENDENTS TO BE ENROLLED OR CHANGED IN MEDICAL, DENTAL, AND/OR VISION.

Name (Last Name, First Name, Middle Initial)	Sex	Birth date MM/DD/YY	Social Security #	Medical
Employee	☐ M ☐ F			X
Spouse (includes civil unions and domestic partners)	☐ M ☐ F			X
Child	☐ M ☐ F			X
Child	☐ M ☐ F			X
Child	☐ M ☐ F			X

4. MEDICAL

Health Plan (choose one)

☐ Aetna ☐ Harvard Pilgrim Health Care
☐ ConnectiCare ☐ UnitedHealthcare/Oxford

Plan (choose one)

☐ HSA $6,000
☐ HSA $4,000/50%
☐ HSA $2,750/10%
☐ POS $30–$2,500/50%
☐ POS $35/$50–$2,850/30%
☐ POS $35/$50–$3,500/25%
☐ POS $30/$45–$3,000/20%
☐ POS $30/$45–$4,000
☐ POS $30/$45–$1,500
☐ POS $25/$40–$2,000

8. LIFE INSURANCE BENEFICIARY INFORMATION

To the EMPLOYER: This is the only record of an employee's beneficiary designation. Please retain a copy and submit it at the time of request for death benefits. This form should also be used for any changes in beneficiary designation. Please record the appropriate date.

Beneficiary Name (Last, First, MI)

Relationship of Beneficiary Date

9. AUTHORIZATION AND ACCEPTANCE

I hereby apply for the health plan and benefit plan selected, understanding all benefits and coverage as specified in the enrollment brochure and agreeing to abide by all the rules and regulations therein specified. I authorize deductions from my earnings of the required contributions, if any, toward the cost of the coverage. The information provided is true and correct to the best of my knowledge. I understand my coverage and benefits may be affected by failure to provide complete and accurate information.

Important: The employee's and employer's signatures are required before submitting this application. CBIA Service Corp. reserves the right to deny or delay enrollment if information or required signatures are missing from this enrollment form.

If you're declining enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this plan, provided you request enrollment within 30 days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, civil union, domestic partner, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents, provided you request enrollment within 30 days after the marriage, civil union, domestic partner, birth, adoption or placement for adoption.

Employee Signature Date

Employer Signature Date

Employer—Please retain a copy for your files

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Connecticut Public Act 09-46
Insurance Company Medical Loss Ratios for 2014

The medical loss ratio is defined as the ratio of incurred claims to earned premium for the prior calendar year for managed care plans issued in Connecticut and shall otherwise be calculated in accordance with the requirements of Connecticut state law. For calendar year 2014, medical loss ratios for insurance companies that participate in CBIA Health Connections are:

Aetna Life Insurance Company*	86.4%
ConnectiCare Insurance Company Inc.*	82.6%
Harvard Pilgrim Health Care	N/A
Oxford Health Plans (CT), Inc.**	85.6%
Oxford Health Insurance, Inc.**	80.4%

* 2014 State Medical Loss Ratio
** Small Group 2014 Federal Medical Loss Ratio

Enrollment Instructions

- Complete all items to avoid delays in processing.
- If you are waiving medical coverage but are enrolling in other coverage, please complete all sections including date of birth, Social Security number and sections indicating the amount of life insurance selected, your salary—if life is salary-based, and your beneficiary. Note: If you do not elect Life, STD or LTD at the time you are first eligible, you will be required to provide Evidence of Insurability.
- If you or one of your dependents is enrolling in our Medicare plan, you must complete this form **and** the Enrollment Forms for the carrier you are enrolling with, and provide a copy of the Medicare card for each person enrolling. All forms must be completed in full, signed and dated to avoid delays in coverage.
- Your signature and date **and** your employer's signature and date must be on the Enrollment/Change Form.
- Dependents are eligible until reaching age 26.
- For Medical enrollment (section 4), choose one carrier and plan.
- For Dental enrollment (section 5), choose one plan. Check with your employer for available dental options.
- For Supplemental Life insurance (section 7), please complete a separate Supplemental Life Insurance Enrollment Form.
- If you reside outside Connecticut and need information on which plans are available, please refer to our website at cbia.com/ins and click on Out-of-Area Information. If you need assistance in determining which health plans or benefits are available to you, contact your agent, or contact CBIA Customer Service at 860.525.2242.
- An affidavit may be required at time of claim to verify domestic partner relationship. See cbia.com for a copy of the affidavit.

Thank you for selecting coverage through CBIA Health Connections.