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:	Town of Bolton
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:	July 1, 2021

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

*Vision coverage can only be taken if you are also taking Medical/RX coverage

	NAME Last, First	Date of Birth	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