

## Connecticut Partnership Plan Add / Term / Change Form

Anthem Group Number:

\*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
Employee Only	<input type="checkbox"/>
Employee + 1	<input type="checkbox"/>
Family	<input type="checkbox"/>
Waiver	<input type="checkbox"/>
COBRA	<input type="checkbox"/>

	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.*

