

<b>1. Tell Us About You</b> Last Name: _____ First Name: _____ M.I.: _____ Home Address: Number and Street or P.O. Box: _____ Apt. #: _____ City: _____ State: _____ Zip Code: _____ Home Telephone: _____ Work Telephone: _____ MARITAL STATUS: <input type="checkbox"/> SINGLE <input type="checkbox"/> LEGALLY SEPARATED <input type="checkbox"/> WIDOWED <input type="checkbox"/> MARRIED <input type="checkbox"/> SEPARATED <input type="checkbox"/> DIVORCED	<b>2. New Membership</b> <input type="checkbox"/> NEW HIRE <input type="checkbox"/> OPEN ENROLLMENT <input type="checkbox"/> COBRA/C.G.S. 38a-538 DATE OF QUALIFYING EVENT: MM / DD / YR REASON: _____ <small>SEE INSTRUCTION SHEET</small>	<b>To Be Completed By Employer</b> Requested Effective Date: 07/01/2019 Firm Division No.: 068965-031 For Office Use Only
<b>3. Change Membership</b> <input type="checkbox"/> CHANGE <input type="checkbox"/> ADDRESS <input type="checkbox"/> NAME INDICATE FORMER NAME <input type="checkbox"/> OTHER REASON DATE OF QUALIFYING EVENT: MM / DD / YR		

<b>4. Your Membership Choices</b> <b>SECOND CONTRACT - VISION ONLY</b> Individual <input type="checkbox"/> Two Person <input type="checkbox"/> Family <input type="checkbox"/> <input type="checkbox"/> BLUE VIEW VISION	Are you or any other eligible dependent listed on this form currently confined to a hospital or other healthcare facility, totally disabled or physically impaired? <input type="checkbox"/> YES <input type="checkbox"/> NO <b>5. Where You Work</b> Capital Area Health Consortium 270 Farmington Avenue Suite 352 Farmington CT 06032-1994 ARE YOU ACTIVELY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO / (IF NO ) REASON <input type="checkbox"/> SICK <input type="checkbox"/> INJURED <input type="checkbox"/> OTHER ARE YOU CURRENTLY CLAIMING WORKERS COMP. MEDICAL BENEFITS? <input type="checkbox"/> YES <input type="checkbox"/> NO DO YOU WORK 30 OR MORE HOURS PER WEEK? <input type="checkbox"/> YES <input type="checkbox"/> NO DATE OF FULL TIME HIRE: _____ DATE OF REHIRE: _____
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6. List Members To Be Added/Cancelled			
SEX	NAME (LAST NAME/FIRST/M.I.)	Add	Cancel
<input type="checkbox"/> M <input type="checkbox"/> F	Self		
<input type="checkbox"/> M <input type="checkbox"/> F	Spouse		

DEPENDENTS: Children over 19 may be eligible if disabled, or unmarried full-time students. Please circle disabled dependent.

<input type="checkbox"/> M <input type="checkbox"/> F	Dependent			MM / DD / YR	
<input type="checkbox"/> M <input type="checkbox"/> F	Dependent			MM / DD / YR	
<input type="checkbox"/> M <input type="checkbox"/> F	Dependent			MM / DD / YR	

<b>7. Tell Us About Your Other Insurance</b>	Do you or any other member of your family have any other medical, dental or Anthem BCBS coverage? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, please fill in the information below. <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Children			
Name of Company: _____	Name of Subscriber (Policyholder): _____	Policy or ID No.: _____	Reason for Termination: _____	First and Last Date of Coverage: _____

8. Medicare/Medicaid						
Do you or any other covered member have Medicare/Medicaid coverage? <input type="checkbox"/> YES <input type="checkbox"/> NO						
Have you or any covered member applied for Medicare/Medicaid disability? <input type="checkbox"/> YES <input type="checkbox"/> NO						
Name(s) of Medicare Beneficiaries	Are you actively at work?	Retirement date (MM/DD/YY)	Health insurance claim no.	Medicare Part A effective date	Medicare Part B effective date	Medicare Part D effective date
	<input type="checkbox"/> YES <input type="checkbox"/> NO	MM / DD / YR				
	<input type="checkbox"/> YES <input type="checkbox"/> NO	MM / DD / YR				
	<input type="checkbox"/> YES <input type="checkbox"/> NO	MM / DD / YR				

I understand that false and/or incomplete responses or statements may result in rescission of coverage and/or non-payment of claims for myself or my eligible dependents. I understand a copy of this application is provided to me as part of my Subscriber Agreement or health benefit plan document as applicable and is incorporated by reference therein. I certify that my statements in this form are true and complete to the best of my knowledge and belief.

<b>9. Employee Signature</b>	Date MM / DD / YR
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Graduate Medical Education  
263 FARMINGTON AVENUE, LM068  
FARMINGTON, CT 06030-1921  
PHONE 860.679.2147  
FAX 860.679.4624



Capital Area Health Consortium  
270 FARMINGTON AVENUE, SUITE 352  
FARMINGTON, CT 06032-1994  
PHONE 860.676.1110  
FAX 860.676.1303

## BLUE VIEW VISION INSURANCE WAIVER

I am declining Blue View Vision Insurance at this time\* \_\_\_\_\_

\_\_\_\_\_

Print Name

\_\_\_\_\_

Signature

\_\_\_\_\_

Date

\*If you do not sign up for Blue View Vision at this time, you can enroll only during the next Open Enrollment which is the month of June with a July 1 effective date.