ACTIVE EMPLOYEE HEALTH ENROLLMENT/CHANGE FORM

CO-744A REV. 2.2021

State Of Connecticut
Office of the State Comptroller
https://carecompass.ct.gov

Type or print and forward to your Agency HR / Payroll Office

You must submit a completed enrollment application and any required documentation to your Agency HR / Payroll Office **within 31 days** of your initial benefits eligibility date or **within 31 days** of a qualified change in family status. Please refer to https://carecompass.ct.gov for your annual Health Care Options Planner for more information. You only need to complete and submit this form if you are wishing to make a coverage update.

① Your Personal Information

Last Name	**First Name, MI**	**Agency**	**Employee Number**

Street Address	**City**	**State**	**Zip Code**

Date of Birth (MM/DD/YYYY)	**Gender** (M/F)	**Home Telephone Number**

Email Address	**Cell/Mobile Telephone Number**

② Application Type

☒ Annual Open Enrollment

☐ Adding/Dropping Dependents

Qualifying Status Change:
- ☐ Marriage
- ☐ Birth/Adoption
- ☐ Change in Dependent Eligibility Status

Date of Event: ____/ ____/ _____
- ☐ Start of Other Coverage
- ☐ Loss of Other Coverage
- ☐ Death of Spouse/Dependent

③ Choose Medical Plan – Select Only One Choice.

Note that your choices will remain in effect throughout this plan year unless you experience a change in family status. Please keep a copy of this form for your records.

☐ No Change – Keep Current Medical Coverage Election

☐ Waive/Cancel Medical and Prescription Coverage

Change Coverage to:

- ☐ Anthem State BlueCare Prime Plus POS *New*
- ☐ Anthem State BlueCare POE Plus POE-G
- ☐ Anthem State BlueCare POE
- ☐ Anthem State BlueCare POS
- ☐ Anthem Out of Area Plan – **Only Available if Employee's Permanent Residence is Outside of Connecticut**
- – Anthem State Preferred POS – **This Option is Closed to New Enrollment**

④ Choose Your Dental Plan Select Only One Choice.

Note that your choices will remain in effect throughout this plan year unless you experience a change in family status. Please keep a copy of this form for your records.

☐ No Change – Keep Current Dental Coverage Election

☐ Waive/Cancel Dental Coverage

Change Coverage to:

- ☐ Basic Dental Plan
- ☐ Enhanced Dental Plan
- ☐ (Total Care DHMO)
- ☐ Dental HMO Plan

⑤ Spouse/Dependent Information List ONLY the dependent(s) that you wish to add or drop to this year's health coverage.

Dependents currently covered will remain covered unless you elect to add or drop them. See eligibility rules on https://carecompass.ct.gov for required documentation.

Name	Relationship	Gender	Date of Birth	Social Security Number	Medical		Dental	
					Add	Drop	Add	Drop
					☐	☐	☐	☐
					☐	☐	☐	☐
					☐	☐	☐	☐
					☐	☐	☐	☐

☐ FLES rate request – If you are enrolling at least one child, your spouse is also an active State of Connecticut employee, and they are enrolled in the same health plan under their own record as Employee Only, you may be eligible for the Family Less Employed Spouse (FLES) rate. Your agency HR/Payroll office will contact you for verification of your spouse's enrollment.

⑥ Signature & Authorization

I hereby apply for membership in the plan(s) above. I understand that if I am changing plans, my current coverage will be canceled when my new coverage takes effect. I understand that the services may be subject to exclusions, limitations, and conditions described by the health plan.

I certify that all information on this form is correct to the best of my knowledge and belief. I understand that providing false and/or incomplete information may result in the loss of coverage and/or nonpayment of claims for me or any ineligible enrollee(s). It is my responsibility to notify my HR / Payroll Agency when a dependent becomes ineligible.

I hereby authorize the State Comptroller to make deductions, if applicable, from my paycheck and/or bill me as necessary for the medical and/or dental insurance indicated above.

Signature	**Date**