Connecticut Partnership Plan 2.0

Enrollment Form

New Enrollee:	☐	Termination:	☐
Change of Name:	☐	Add Dependent:	☐
Change of Address:	☐	Term Dependent:	☐

EMPLOYER	
EMPLOYEE NAME (Last, First)	
EMPLOYEE Street Address	
City, State & Zip	
DATE OF HIRE	
EFFECTIVE DATE	

COVERAGE ELECTIONS:	Medical/RX	Dental
Employee Only	☐	☐
Employee + Dependent	☐	☐
Family	☐	☐
Waiver	☐	☐
COBRA	☐	☐

	NAME Last, First	DOB	Social Security Number	Gender	Add/Term
EMPLOYEE					
DEPENDENT (Spouse)					
DEPENDENT (Child)					
DEPENDENT (Child)					
DEPENDENT (Child)					
DEPENDENT (Child)					
DEPENDENT (Child)					
DEPENDENT (Child)					

MEDICARE ELIGIBLE COVERAGE ELECTIONS:	MEDICAL	DENTAL
Part A	☐	☐
Part B	☐	☐

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.