ConnectiCare

# SOLO Individual Application/Change Form

Thank you for your interest in ConnectiCare Individual Health Insurance. Now that you have found the right plan for you, here's how to apply for coverage:

- Online: Go to www.connecticare.com/solo and complete an online application and click "Submit" for processing.
- With a Broker: Ask your broker to send you an email invitation with details about your plan options and a link to the online application.
- Paper form: If you can't apply online, you can use this paper form, please allow up to 14 days to process. Applications should be mailed to: ConnectiCare, Inc. and Affiliates, ATTN: SOLO Intake, 175 Scott Swamp Road, Farmington, CT 06034 or fax 860-678-5274

**Open Enrollment:**

For 2021, the annual open enrollment period will be November 1, 2020 through December 15, 2020 for coverage effective January 1, 2021.

**Special Enrollment Period:**

An individual can experience a qualifying life event that makes him/her eligible to apply for health care coverage outside of the annual open enrollment period. If you have experienced a qualifying life event, you can apply for coverage within 60 days following the event, except in the case of pregnancy, you must apply within 30 days of commencement of pregnancy.

If you apply for a Special Enrollment period based on pregnancy, you must apply within 30 days of the commencement of the pregnancy, as certified by a licensed health care provider acting within the scope of that health care provider's practice.

*Continued* ↳

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P.O. Box 4058, Farmington, CT 06034-4058 ■ www.connecticare.com ■ 1-800-723-2986 (Sales Dept.)

## APPLICANT INFORMATION:

☐ New Application ☐ Qualifying Event ☐ Renewal: Policy# _____
☐ Renewal Plan Change ☐ Add Dependent ☐ Remove Dependent ☐ Other _____

Effective Date (mm/dd/yyyy)

Marital Status ☐ Single ☐ Married (Civil Union) ☐ Legally Separated ☐ Domestic Partnership (Affidavit Required)

Email Address

Primary Telephone Number
☐ Home ☐ Cell ☐ Work

Secondary Telephone Number
☐ Home ☐ Cell ☐ Work

Residential Street Address (PO Box alone not accepted)

City | State | ZIP Code

Billing Address (if different from Residential Address – PO Box is accepted)

City | State | ZIP Code

## AGENT SECTION:

Agency Name | E-mail:

Agent Name (Print) | Agent Signature ▶

| **List all applying for coverage** (First name, MI, Last name) | **Date of Birth** (mm/dd/yyyy) (Required for all Applicants) | **Gender** | **Social Security Number** (Required for all Applicants) | **Primary Care Provider** | **Existing Patient** |
|---|---|---|---|---|---|
| Applicant: | | ☐ M ☐ F | | ID# | ☐ Y ☐ N |
| * ☐ White ☐ Black/African American ☐ Hispanic/Latino ☐ Asian ☐ Amer. Indian/Alaska Native ☐ Native Hawaiian/Pacific Islander ☐ Other ☐ Unknown | | | | | |
| Spouse/Civil Union/Domestic Partner**: | | ☐ M ☐ F | | ID# | ☐ Y ☐ N |
| * ☐ White ☐ Black/African American ☐ Hispanic/Latino ☐ Asian ☐ Amer. Indian/Alaska Native ☐ Native Hawaiian/Pacific Islander ☐ Other ☐ Unknown | | | | | |
| Dependent 1: | | ☐ M ☐ F | | ID# | ☐ Y ☐ N |
| * ☐ White ☐ Black/African American ☐ Hispanic/Latino ☐ Asian ☐ Amer. Indian/Alaska Native ☐ Native Hawaiian/Pacific Islander ☐ Other ☐ Unknown | | | | | |
| Dependent 2: | | ☐ M ☐ F | | ID# | ☐ Y ☐ N |
| * ☐ White ☐ Black/African American ☐ Hispanic/Latino ☐ Asian ☐ Amer. Indian/Alaska Native ☐ Native Hawaiian/Pacific Islander ☐ Other ☐ Unknown | | | | | |
| Dependent 3: | | ☐ M ☐ F | | ID# | ☐ Y ☐ N |
| * ☐ White ☐ Black/African American ☐ Hispanic/Latino ☐ Asian ☐ Amer. Indian/Alaska Native ☐ Native Hawaiian/Pacific Islander ☐ Other ☐ Unknown | | | | | |

*__Race/Ethnicity (optional):__ This information is designed for the purpose of data collection and will not be used to determine eligibility, rating or claim payment.

**__Domestic Partner:__ Affidavit of Domestic Partnership Form must be completed and submitted with the application

## Other insurance information (REQUIRED FIELDS)

Will this policy replace any other health insurance policy currently active? ☐ Yes ☐ No
If yes, Name of other insurance carrier _____ If ConnectiCare, provide policy number: _____

Type of coverage
☐ Employer ☐ Individual

Are you or any of your dependents enrolled in Medicare or any Medicare Advantage Program? ☐ Yes ☐ No

If yes, name of person and coverage type:_____

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**ConnectiCare, Inc. = HMO Benefit Plans and ConnectiCare Insurance Company, Inc. = POS Benefit Plans.**
**Pharmacy is included in all plan options. Please Select One:**

| **POS Benefit Plans – In-Network Deductible = Individual/Family:** | **Virtual Plans:** |
|---|---|
| ☐ Choice SOLO POS Copay/Coins. $5,500 ded. | ☐ SOLO Virtual HMO Copay/Coins. $7,500 ded. |
| ☐ Choice SOLO POS Copay/Coins. $4,500 30% ded. | ☐ SOLO Virtual HMO Copay/Coins. $2,000 ded. |
| ☐ Choice SOLO POS Copay/Coins. $4,500 40% ded. | Virtual plans have $0 copays for unlimited virtual visits with Teladoc® doctors and licensed nurses. Teladoc health care professionals can diagnose, treat and prescribe medication for a wide range of non-emergency conditions. |
| ☐ Choice SOLO POS Coins. $3,250 ded. | |

**HSA Compatible Plans Ded. = Individual/Family:**

| | |
|---|---|
| ☐ Choice SOLO HMO HSA $6,500 ded.<br>☐ Choice SOLO POS HSA Coins. $6,500 ded.<br>☐ Choice SOLO POS HSA Coins. $3,500 ded. | **Health Savings Account (HSA)** An HSA is a tax-free fund that can be used to pay for qualified medical and/or pharmacy expenses. ConnectiCare has partnered with Health Equity to provide this service for our customers. Benefits include a full integration of enrollment and claim payments. **Please confirm if you would like to open an account with Health Equity** ☐ Yes ☐ No |

***Passage Plans:**

☐ Passage SOLO HMO Copay/Coins. $7000 ded. ☐ Passage SOLO POS Copay/Coins. $2,200 ded.
*Members must select a PCP from the Passage network and include the PCP's name on the application. Referrals are required from your Passage PCP to see some specialists. Find participating Passage network PCPs with the "Find a Doctor" tool on connecticare.com

**Adult Dental:** ☐ $25 Deductible, 100%/100%/0%, unlimited max, no ortho
Note: Pediatric Dental coverage for children age 20 or younger is included under the medical plan

## STATEMENT OF ACCOUNTABILITY

**To be completed when the applicant cannot complete the application.**

I, _____, personally read and completed this Application for the applicant named below because:

☐ Applicant does not read English ☐ Applicant does not speak English ☐ Applicant does not write English

☐ Other (explain): _____

I am qualified to translate the contents of this form and translated this information to: _____

To the best of my knowledge I obtained and listed all information disclosed by this applicant. I also translated and fully explained the statements above.

_____
Signature of Translator (required) Today's Date

## TERMS, CONDITIONS AND CONSENT

**Important:** [The applicant, spouse/partner and all dependents aged 18 and over must sign this form]. By [selecting I (we) agree] signing here I acknowledge and agree that I am a resident of the State of CT and I have read and understand the information on all pages of this Application. I also agree that the Member Consent below is valid as long as I am enrolled in a ConnectiCare health plan. I certify that I have personally completed this application on behalf of myself and on behalf of my dependents listed on the application who are under the age of 18. I represent that the answers and statements made herein are true, complete and correctly recorded to the best of my knowledge and belief. I acknowledge that I have received a copy of the Outline of Coverage for the Plan I have selected above. I acknowledge and agree that with respect to any dependents under age 18 that I am authorized to make these statements on their behalf. I further understand and agree that: (1) this application does not give me immediate coverage; (2) the broker is only authorized to submit this application; (3) if I have knowingly provided incorrect or incomplete information on this application that ConnectiCare may rescind any policy within 2 years of issuance. This means that ConnectiCare will cancel coverage as if the policy never existed; and (4) I have personally read and completed this application and that application will become part of the contract between ConnectiCare and me and I agree to abide by the terms of that contract. I understand that the phone number(s) I provided on this application may be used by ConnectiCare or any of its contracted parties to contact me about my account, the provision of services to me or my health benefit plan or related programs. **THIS PLAN IS ISSUED ON AN INDIVIDUAL BASIS AND IS REGULATED AS AN INDIVIDUAL HEALTH INSURANCE PLAN.**

► _____
Applicant Signature Date

_____
Print name of parent/guardian (if applicable)

► _____
Spouse/Partner Signature (if applicable) Date

► _____
Dependent Signature (age 18 years-over) Date

► _____
Dependent Signature (age 18 years-over) Date

► _____
Dependent Signature (age 18 years-over) Date

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**IMPORTANT: MEMBER CONSENT**

On my behalf and on behalf of my spouse and/or dependent(s), I hereby authorize any physician, hospital, provider, insurer, ConnectiCare Inc., (CCI) or a CCI affiliate, or other organization or person having records, data or information concerning health history or medical insurance for me or my family member(s), including but not limited to information concerning mental health, alcohol/substance abuse or HIV or AIDS-related conditions, to transfer to any person or company such records, data or information as may be required for the purpose of providing treatment, paying claims, conducting investigations, meeting CCI's contractual obligations and performing other operations to administer my Benefit Plan. I understand that CCI's privacy notice contains a more complete description of the purposes for which information about me and my dependent(s) may be used or disclosed and that I have a right to review the privacy notice prior to signing this consent. I understand that CCI may change such notice at any time but will provide me a copy of any amended notice. I understand that I have a right to request restrictions on how information about me and my dependent(s) may be used or disclosed to carry out the plan administration purposes and that CCI is not required to agree to the requested restrictions. I understand that this authorization is valid for the term of my and my dependents' coverage under the Plan. I understand that I have the right to revoke this authorization of release of medical records at any time by giving written notice to CCI as long as CCI or others have not taken action relying on this authorization. I understand that, if I exercise such right, CCI may not be able to settle a claim, and CCI can terminate my insurance policy because my revocation of authorization prevents CCI from paying claims, conducting an investigation, meeting CCI's contractual obligations and/or performing other operations to administer my Benefit Plan. I acknowledge that I have retained a copy of this authorization.

I understand that any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals, for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime punishable by penalties, imprisonment and restitution depending on applicable laws.

**Disclosure of Medical Loss Ratio**

The medical loss ratio is defined as the ratio of incurred claims to earned premium for the prior calendar year for managed care plans issued in Connecticut. Claims shall be limited to medical expenses for services and supplies provided to enrollees and shall not include expenses for stop loss, reinsurance, enrollee educational programs, or other cost containment programs or features.

The Federal medical loss ratio has the same meaning as provided in and calculated in accordance with PPACA, PL 111-148, as amended from time to time, and regulations adopted thereunder.

- State Medical Loss Ratio for calendar year 2019 for ConnectiCare, Inc. (CCI): 88.0%
- Federal Medical Loss Ratio for calendar year 2019 for ConnectiCare, Inc. (CCI):
  Individual 96.2%
  Small-Group N/A
  Large-Group 87.8%
- State Medical Loss Ratio for calendar year 2019 for ConnectiCare Insurance Company, Inc. (CICI): 83.6%
- Federal Medical Loss Ratio for calendar year 2019 for ConnectiCare Insurance Company, Inc. (CICI):
  Individual 86.6%
  Small-Group 82.9%
  Large-Group 89.6%

| **FOR BUSINESS USE ONLY:** | |
|---|---|
| Date Received: | Date Processed/Initials: |
| Date Audited/Initials: | Account Number: |

ConnectiCare

# Qualifying Event Attestation

An individual can experience a **qualifying event** that makes him/her eligible to apply for health care coverage outside the Open Enrollment Period. This is called a **Special Enrollment Period**. This Attestation attests to my eligibility for Special Enrollment Period. By signing below, I hereby attest to the following:

To the best of my knowledge, I am eligible to apply because I have experienced the qualifying event selected below on _____/_____/_____:
Month Day Year

- ☐ **Lost my coverage**
  An individual and/or any dependents lose Minimum Essential Coverage (MEC) not resulting from failure to pay premium or providing false information on a previous application
- ☐ **I lost my employer group coverage**
  - ☐ Termination of employment
  - ☐ Death of a covered employee
  - ☐ Covered employee's eligibility for Medicare
  - ☐ Reduction in the number of hours
  - ☐ Employer no longer offers health coverage
- ☐ **Gained or became a dependent**
  - ☐ Through Marriage
  - ☐ Birth, adoption, or placement for adoption or foster care
- ☐ **Other reasons**
  - ☐ Child support order or other court order
  - ☐ Divorce or legal separation
  - ☐ End of Dependent status (dependent turned 26)
  - ☐ An individual gets medical confirmation of a pregnancy by a licensed health care provider, in writing, within the first 30 days of the commencement of the pregnancy
  - ☐ Change in eligibility for advanced premium tax credits or cost sharing reductions
  - ☐ Moved into the ConnectiCare service area
  - ☐ Error in enrollment
  - ☐ Plan or other carrier violated a provision of the contract for my plan
  - ☐ Released from Incarceration (jail or prison)

- I understand that I am required to provide proof of my qualifying event and coverage will not begin until ConnectiCare receives and validates this proof
- I understand and agree that if I have knowingly provided incorrect or incomplete information, ConnectiCare may rescind my policy within 2 years of issuance, which means that ConnectiCare will cancel coverage as if the policy never existed
- I acknowledge that any person/company that suffers any loss due to any false statement contained in this Attestation may bring a civil action against me to recover his/her losses, including attorney fees
- I understand that any act, practice or omission that constitutes fraud or intentional misrepresentation of material fact found in this Attestation/Application is a crime punishable by penalties, imprisonment and/or restitution depending on applicable laws and may result in the denial of benefits, rescission or cancellation of my coverage

_____
Print Name

_____
Signature Date

# Accessibility and Nondiscrimination Notice

ConnectiCare complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. ConnectiCare does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

ConnectiCare:

- Provides free aids and services to people with disabilities to communicate effectively with us, including qualified interpreters and information in alternate formats.
- Provides free language services to people whose primary language is not English, including translated documents and oral interpretation.

If you need these services, contact The Committee for Civil Rights.

If you believe that ConnectiCare has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

The Committee for Civil Rights, ConnectiCare, 175 Scott Swamp Road, Farmington, CT 06032, Phone: 1-800-251-7722, and TTY: 711. You can file a grievance in person or by mail. If you need help filing a grievance, The Committee for Civil Rights is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 800-537-7697 (TDD).

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Continued →

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-251-7722 (TTY: 711).

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-800-251-7722 (TTY: 711).

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-800-251-7722 (TTY: 711).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電1-800-251-7722 (TTY: 711）。

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-251-7722 (TTY: 711).

ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-251-7722 (ATS: 711).

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-800-251-7722 (TTY: 711).

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-251-7722 (телетайп: 711).

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-251-7722 (TTY: 711).

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-251-7722 (رقم هاتف الصم والبكم: 711 ).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-251-7722 (TTY: 711)번으로 전화해 주십시오.

KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Telefononi në 1-800-251-7722 (TTY: 711).

ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-800-251-7722 (TTY: 711) पर कॉल करें।

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-251-7722 (TTY: 711).

ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, στη διάθεσή σας βρίσκονται υπηρεσίες γλωσσικής υποστήριξης, οι οποίες παρέχονται δωρεάν. Καλέστε 1-800-251-7722 (TTY: 711).

ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 1-800-251-7722 (TTY: 711)។

સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-800-251-7722 (TTY: 711).