2016 Individual Enrollment Application/Change Form

I want to

- ☐ Get new insurance for
  - ☐ Myself
  - ☐ Myself and my Family
  - ☐ My Child or Children
- ☐ Make a change
  - ☐ Add a Dependent
  - ☐ Remove a Dependent
  - ☐ Change my Benefit Plan
  - ☐ Name and/or Address
  - ☐ Marital Status
  - ☐ Other Coverage
  - ☐ Cancel my Coverage

The date I want my new coverage or change to take effect is:

Is this a Special Enrollment?

☐ Yes ☐ No

You can apply for coverage outside of the open enrollment period through a **Special Enrollment** if you:

- Have a qualifying life event (see Special Enrollment Verification form for more details).
- Apply within 60 days of the date of the qualifying event.
- Submit certain documents to verify the life event.
- Visit www.healthyct.org/forms to download the Special Enrollment Verification form.
  - Print, complete and submit it along with this Individual Enrollment Application/ Change form and your documents

This section is for information about you.

Applicant Name (First Name, Middle Initial, Last Name)				Date of Birth
Social Security Number*	Sex ☐ Female ☐ Male	Relationship Status ☐ Single ☐ Married ☐ Divorced ☐ Domestic Partnership		
Phone Number		Email Address		
Race/Ethnicity (Optional)		Preferred Language (Optional)		
Mailing Address				
Street Name	P.O. Box	Town/City	State	Zip Code
Billing Address (If different from Mailing Address)				
Street Name		Town/City	State	Zip Code
Primary Care Physician (PCP)				
Doctor's Name	Address			

This section is for information about other people covered under your policy.

Dependent Name First Name, Middle Initial, Last Name	**Relationship** Spouse/Child/ Other	**Date of Birth**	**Sex**	**Social Security Number***	**PCP Name and Location**	**If over 26, is dependent disabled?****
						☐
						☐
						☐
						☐

*The Internal Revenue Service requires us to collect Social Security numbers for you and your dependents.

**Download a disabled dependent form from our website, www.healthyct.org, or call us at 1-855-HLTHYCT (1-855-458-4928) and submit with your application.

Complete this section if a Broker helped you apply for coverage.

Broker Information	
Broker Name	Broker ID Number (from Broker)

-over-

Other Coverage

Please complete this section only if you or a dependent will have coverage through another plan while you have coverage through HealthyCT. For example, employer-sponsored insurance, Medicaid, Tricare, etc. This information is to be used for coordination of benefits to determine which plan is primary to pay claims.

Other Coverage				
Name(s) of individual(s) who will have other coverage				
Existing Carrier Name	Member ID#	Group ID#	Effective Date	Expiration Date
Will our new HealthyCT plan replace you and/or your dependents' other coverage? ☐ Yes ☐ No				

Choose a HealthyCT Plan

If you'd like to view and download your plan's most up-to-date Certificate of Coverage and Summary of Benefits and Coverage, please visit **www.healthyct.org** and click "Explore Our Plans." You can also check out the Uniform Glossary of Health Coverage and Medical Terms at **www.healthyct.org/glossary**. For a printed copy of these documents – free of charge – please call us at **1-855-458-4928**.

Gold	Silver	Bronze	Catastrophic
☐ Gold Preferred Standard PPO	☐ Silver Enhanced Standard PPO	☐ Bronze Basic Standard PPO	☐ Basic Catastrophic PPO
☐ Gold Preferred PPO 1	☐ Silver Enhanced PPO 1	☐ Bronze Basic Standard HSA	
☐ Gold Preferred PPO 2	☐ Silver Enhanced PPO 2	☐ Bronze Basic HSA 1	
☐ Gold Preferred PPO 7	☐ Silver Enhanced PPO 3	☐ Bronze Basic HSA 3	
	☐ Silver Enhanced PPO 4		
	☐ Silver Enhanced PPO 5		
	☐ Silver Enhanced PPO 6		
	☐ Silver Enhanced PPO 7		
	☐ Silver Enhanced HSA 2		
	☐ Silver Enhanced HSA 4		
	☐ Silver Enhanced HSA 7		

I certify that I have personally completed this form on behalf of myself and my dependents listed on the application and that I am authorized to complete this application on behalf of such dependents. I represent that the answers and statements made by me in this application are true and complete to the best of my knowledge. I understand that I have an obligation to inform HealthyCT of any changes to information included on this application that occur after I sign this application and before the effective date of my policy or during the period of my coverage. I also understand that this application does not give me immediate coverage - my coverage will be effective only upon written notice from HealthyCT. Finally, I understand that if I have knowingly provided incorrect or incomplete information on this application, HealthyCT may cancel or rescind my policy.

Signature: ____ Name: ____ Date: __________________

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State Medical Loss Ratio: 101.4%

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, enroll educational programs, or other cost containment programs or features.

Federal Medical Loss Ratio: Individual: 97.8%
Small Group: 81.2%
Large Group: 114.1%

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