Connecticut Partnership Plan 2.0

Enrollment Form for New Enrollee

New Enrollee: ☐

Oxford CSP Code: ☐

Cigna Branch Code: ☐

**For HR Use only*

EMPLOYER NAME:

EMPLOYEE NAME:
(Last, First)

EMPLOYEE
STREET ADDRESS:

CITY, STATE & ZIP:

EMPLOYEE PHONE NUMBER:

**Note: Phone number is vitally important. Without a valid phone number, we are unable to contact members regarding clinical programs or HEP programs.*

EFFECTIVE DATE:

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

	NAME Last, First	Date of Birth	Social Security Number	Gender	Add
EMPLOYEE					Add
DEPENDENT (Spouse)					Add
DEPENDENT (Child)					Add
DEPENDENT (Child)					Add
DEPENDENT (Child)					Add
DEPENDENT (Child)					Add
DEPENDENT (Child)					Add
DEPENDENT (Child)					Add

MEDICARE ELIGIBLE COVERAGE ELECTIONS:	MEDICAL/RX	DENTAL	VISION
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.

UnitedHealthcare Oxford

OFFICE of the STATE COMPTROLLER