Application Submission Instructions

Please complete the attached application and send to HealthPlanOne either via fax or mail:
(must submit by mail if enclosing a check or money order)

HealthPlanOne
35 Nutmeg Drive, Suite 220
Trumbull, CT 06611

Fax (Toll Free): 888.812.6887

Please make check payable to the carrier to which you are applying.

Any questions? Please call HealthPlanOne at 1-877.567.5267. Thank you!

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:

- Go to www.connecticare.com/solo and fill out the online application. Within 24 hours, you will get an email from us confirming your coverage.
- Or, ask your broker to send you an email invitation with details about your plan options and a link to the online application.

Please note: If you can't apply online, you can use this paper form, but it may take up to seven to 14 days to process. For applicants under the age of 18, a parent or guardian must sign and date the application form online or on paper. Applications should be mailed to: ConnectiCare, Inc. and Affiliates, ATTN: SOLO Intake, 175 Scott Swamp Road, Farmington, CT 06034.

Eligibility Period

Open Enrollment:

For 2017, the annual open enrollment period will be November 1, 2016, through January 31, 2017.

2017 Open Enrollment Period	
Open Enrollment	**Coverage Effective Dates**
If enrolled November 1, 2016 – December 15, 2016	Coverage effective January 1, 2017
If enrolled December 16, 2016 – January 15, 2017	Coverage effective February 1, 2017
If enrolled January 16, 2017 – January 31, 2017	Coverage effective March 1, 2017

Special Enrollment Period:

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. If you have experienced a qualifying event, you can apply for coverage within 60 days following the event. Examples of a qualifying event include:

- An individual and/or any dependents lose Minimum Essential Coverage (MEC) not resulting from failure to pay a premium or providing false information on a previous application
- An individual gains or becomes a dependent through birth, adoption, or placement for adoption
- An individual gains or becomes a dependent through marriage
- An individual gained a dependent through court order, including child support
- An individual experiences an error in enrollment
- An individual adequately demonstrates that the plan or other carrier substantially violated an important provision of the contract in which he or she is enrolled
- Eligibility for advanced premium tax credits or cost sharing reductions changed

Continued ↳

- Moved into the ConnectiCare service area and had Minimal Essential Coverage (MEC) in the preceding 60 days. **Note:** MEC is not required if you moved to CT from another country.
- A dependent loses coverage because of the death of a covered employee under a group plan
- The termination (other than for misconduct) or reduction of hours of a covered employee's employment that results in a loss of group health coverage
- Employer no longer offers coverage
- Released from Incarceration (jail or prison) **Note:** MEC is not required if you are recently released from incarceration.
- The divorce or legal separation that results in a loss of group health coverage
- A covered dependent loses group health coverage because of a covered employee's eligibility for Medicare
- A dependent child loses coverage due to loss of dependent status under an employee's group health plan

ConnectiCare

SOLO Individual Application/Change Form

P.O. Box 4058, Farmington, CT 06034-4058 ■ www.connecticare.com ■ 1-800-251-7722 (Member Services)

APPLICANT INFORMATION: Complete all sections, sign at bottom and read information on reverse side.

Check one: ☐ New Application/Open Enrollment ☐ New Application/Qualifying Event ☐ Add Dependent ☐ Renewal Plan Change ☐ 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: HEALTHPLANONE, LLC

Phone Number: 877-567-5267

Agent Name (Print): HEALTHPLANONE, LLC

Agent Signature ▶

APPLICANT(S):	**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.

Other insurance information: Do you have any other health insurance policy currently active? ☐ Yes ☐ No

Name of other insurance company

Type of coverage ☐ Employer ☐ Individual

Do you intend to replace your current medical or health policy with this policy? ☐ Yes ☐ No

ConnectiCare

SOLO Individual Application/Change Form

ConnectiCare, Inc. = HMO Benefit Plans and ConnectiCare Insurance Company, Inc. = POS Benefit Plans

POS Benefit Plans – In-Network Deductible = Individual/Family (Pharmacy is included in all plan options) Select one:

☐ Choice SOLO Copay/Coins. $1,000/$2,000 ded.
☐ Choice SOLO Copay/Coins. $4,500/$9,000 ded.
☐ Choice SOLO Copay/Coins. $5,000/$10,000 ded.
☐ Choice SOLO Coins. $2,500/$5,000 upfront ded.

HSA Compatible Plans Ded. = Individual/Family (Pharmacy is included in all plan options) Select one:

☐ Choice SOLO HSA Coins. $3,000/$6,000 ded.
☐ Choice SOLO HSA $6,000/$12,000 ded.
☐ Choice SOLO HMO HSA $5,850/$11,700 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 payment.

Please confirm if you like to open an account with Health Equity
☐ Yes ☐ No

Adult Dental:

☐ $25 Deductible, 100%/0%/0%, unlimited max, no ortho

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

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 have read and understand the information on the front **and back** of this form. 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

ConnectiCare

SOLO Individual Application/Change Form

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 contactual 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 2015 for ConnectiCare, Inc. (CCI): 86.5%
- Federal Medical Loss Ratio for calendar year 2015 for ConnectiCare, Inc. (CCI):

Individual	95.3%
Small-Group	88.0%
Large-Group	89.5%

- State Medical Loss Ratio for calendar year 2015 for ConnectiCare Insurance Company, Inc. (CICI): 88.3%
- Federal Medical Loss Ratio for calendar year 2015 for ConnectiCare Insurance Company, Inc. (CICI):

Individual	96.8%
Small-Group	84.1%
Large-Group	88.8%

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)
  - ☐ 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 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 06034, 1-800-251-7722, and TTY number 1-800-833-8134. You can file a grievance in person at 175 Scott Swamp Road, Farmington, CT, or by mail, or fax (860) 674-2232. 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 of 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

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-251-7722 (TTY: 1-800-833-8134).

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-800-251-7722 (TTY: 1-800-833-8134).

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-800-251-7722 (TTY: 1-800-833-8134).

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: 1-800-833-8134)。

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-251-7722 (TTY: 1-800-833-8134).

ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-251-7722 (ATS: 1-800-833-8134).

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-800-251-7722 (TTY: 1-800-833-8134).

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-251-7722 (телетайп: 1-800-833-8134).

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: 1-800-833-8134).

ملحوظة: إذا كنت تتحدث اللغة العربية، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان.
اتصل برقم 1-800-251-7722 (والصم والبكم: 1-800-833-8134).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-251-7722 (TTY: 1-800-833-8134)번으로 전화해 주십시오.

KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Telefononi në 1-800-224-2273 (TTY: 1-800-842-9710).

ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-800-224-2273 (TTY: 1-800-842-9710) पर कॉल करें।

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-224-2273 (TTY: 1-800-842-9710).

ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, στη διάθεσή σας βρίσκονται υπηρεσίες γλωσσικής υποστήριξης, οι οποίες παρέχονται δωρεάν. Καλέστε 1-800-224-2273 (TTY: 1-800-842-9710).

ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 1-800-224-2273 (TTY: 1-800-842-9710)។

સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-800-224-2273 (TTY: 1-800-842-9710).