

Connecticut Partnership Plan 2.0

Enrollment Form

New Enrollee: <input checked="" type="checkbox"/>	Termination: <input type="checkbox"/>
Change of Name: <input type="checkbox"/>	Add Dependent: <input type="checkbox"/>
Change of Address: <input type="checkbox"/>	Term Dependent: <input type="checkbox"/>

EMPLOYER	Town of Trumbull
EMPLOYEE (Last, First)	
EMPLOYEE Street Address	
City, State & Zip	
DATE OF HIRE	
EFFECTIVE DATE	July 1, 2016

COVERAGE ELECTIONS:	Medical/Rx/Vision	Dental
Employee	<input type="checkbox"/>	<input type="checkbox"/>
Employee + Dependent	<input type="checkbox"/>	<input type="checkbox"/>
Family	<input type="checkbox"/>	<input type="checkbox"/>
Waiver	<input type="checkbox"/>	<input type="checkbox"/>
COBRA	<input type="checkbox"/>	<input type="checkbox"/>

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

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.

