

**ConnectiCare, Inc. & Affiliates Individual Application/Change Form Part 1** (page 1 of 2)

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

<b>APPLICANT INFORMATION: Complete all sections, sign at bottom and read information on reverse side.</b>												
Check one: <input type="checkbox"/> New Application <input type="checkbox"/> Add Dependent <input type="checkbox"/> Change Ind. Plan Choice (select new choice below) <input type="checkbox"/> Other (Name change, address change, etc.) Indicate change _____							Eff. Date (mm/dd/yy) / /					
Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married (Civil Union) <input type="checkbox"/> Legally Separated <input type="checkbox"/> Separated <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> Domestic Partnership <small>(include "Statement of Domestic Partnership")</small>						Email Address						
First Name		Middle Name			Last Name							
Street Address							Home Telephone Number					
City		State			ZIP Code		Work Telephone Number					
P.O. Box/Billing Address (if different from street address)				City		State		ZIP Code				
ConnectiCare, Inc. = HMO Benefit Plans and ConnectiCare Insurance Company, Inc. = POS Benefit Plans												
<b>HMO Benefit Plans (Select one)</b> (Deductible=Individual/Family): <input type="checkbox"/> HMO \$25/\$35 Hospital Copay \$500 <input type="checkbox"/> HMO \$30/\$45 Hospital Copay \$500 with Radiology Copay* <input type="checkbox"/> HMO Hospital Deductible \$2,000/\$4,000 <input type="checkbox"/> HMO Upfront Plan Deductible \$1,500/\$3,000 <input type="checkbox"/> HMO Upfront Plan Deductible \$2,500/\$5,000 <b>Pharmacy Co-Pay (Select one):</b> <input type="checkbox"/> \$10/\$20/\$35 <input type="checkbox"/> \$15/\$25/\$40 <b>Pharmacy Annual Maximum (Select one):</b> <input type="checkbox"/> \$1,000 <input type="checkbox"/> \$2,000 <input type="checkbox"/> \$3,000 <small>*Plan only available with \$20/50%/50%/\$3,000 Rx</small>			OR			<b>POS Upfront Plan Deductible Benefit Plans</b> (Select one) (Deductible=Individ./Family): <input type="checkbox"/> \$500/\$1,000 In-Network Deductible <input type="checkbox"/> \$1,000/\$2,000 In-Network Deductible <input type="checkbox"/> \$2,000/\$4,000 In-Network Deductible <b>Pharmacy Co-Pay (Select one):</b> <input type="checkbox"/> \$10/\$20/\$35 <input type="checkbox"/> No Pharmacy Option <input type="checkbox"/> \$15/\$25/\$40 <b>Pharmacy Annual Maximum (Select one):</b> <input type="checkbox"/> \$1,000 <input type="checkbox"/> \$3,000 <input type="checkbox"/> \$2,000 <input type="checkbox"/> No Pharmacy Option			<b>HSA Compatible Plans</b> (Select one HMO plan or POS plan) (Deductible=Individual/Family): <b>HMO HDHP</b> <input type="checkbox"/> \$1,500/\$3,000 In-Network Ded. <input type="checkbox"/> \$3,000/\$6,000 In-Network Ded. <input type="checkbox"/> \$5,000/\$10,000 In-Network Ded. <b>POS HDHP</b> <input type="checkbox"/> \$1,500/\$3,000 In-Network Ded. <input type="checkbox"/> \$3,000/\$6,000 In-Network Ded. <input type="checkbox"/> \$5,000/\$10,000 In-Network Ded.			
<b>MEMBER(S):</b>												
First Name/Middle Initial/Last Name		Add	Delete	Social Security Number or Current Member Identification Number		Sex	Date of Birth (mm/dd/yy)	Full-Time Student** <small>age 19 &amp; older</small>	Primary Care Physician	Provider ID Number (6 or 8 digits)	Existing Patient	
Applicant						<input type="checkbox"/> M <input type="checkbox"/> F	/ /				<input type="checkbox"/> Yes <input type="checkbox"/> No	
Spouse/Partner						<input type="checkbox"/> M <input type="checkbox"/> F	/ /				<input type="checkbox"/> Yes <input type="checkbox"/> No	
Dependent 1						<input type="checkbox"/> M <input type="checkbox"/> F	/ /	<input type="checkbox"/> Yes* <input type="checkbox"/> No			<input type="checkbox"/> Yes <input type="checkbox"/> No	
Dependent 2						<input type="checkbox"/> M <input type="checkbox"/> F	/ /	<input type="checkbox"/> Yes* <input type="checkbox"/> No			<input type="checkbox"/> Yes <input type="checkbox"/> No	
Dependent 3						<input type="checkbox"/> M <input type="checkbox"/> F	/ /	<input type="checkbox"/> Yes* <input type="checkbox"/> No			<input type="checkbox"/> Yes <input type="checkbox"/> No	
<input type="checkbox"/> Check if enrolling a disabled dependent age 19 or over and submit a ConnectiCare proof of disability form. *Complete student verification form.												
Tell us about your other insurance: Do you have any other health insurance policy or certificate in force? <input type="checkbox"/> Yes <input type="checkbox"/> No												
Name of other insurance company				Type of coverage <input type="checkbox"/> Group <input type="checkbox"/> Individual			Last date of coverage					
Do you intend to replace your current medical or health policy with this policy? <input type="checkbox"/> Yes <input type="checkbox"/> No												

<b>AGENT SECTION:</b>	
Agency Name <i>RONALD S. GAMBARDI</i>	Phone Number <i>203-201-5572</i>
Agent Name (Print) <i>RON GAMBARDI</i>	Agent Signature <i>R. Gambardi</i>

<b>FOR BUSINESS USE ONLY:</b>	
Effective Date	
Account #	Other

**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 and Part 2: Health Statement. 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 and in Part 2 Health Statement are true, complete and correctly recorded to the best of my knowledge and belief. I understand that I have an obligation to notify ConnectiCare of any new conditions or changes in health condition that may occur after this application is signed and before any approval of my application. 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) ConnectiCare may decline my application and that this application and the initial premium do not give me immediate coverage; (2) the broker has no authority to promise coverage or to modify ConnectiCare's underwriting policy and is only authorized to submit this application and the initial premium payment; (3) if I have provided incorrect or incomplete information on this application and/or Health Statement that ConnectiCare may rescind any policy issued. This means that ConnectiCare will cancel coverage as if the policy never existed; and (4) I have personally read and completed this application and Health Statement and that if I am accepted that this application/Health Statement will become part of the contract between ConnectiCare and me and I agree to abide by the terms of that contract.

**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)	▶ _____	Dependent Signature (age 18 years-over)
			_____ Date
▶ _____	Spouse/Partner Signature (if applicable)	▶ _____	Dependent Signature (age 18 years-over)
	_____ Date		_____ Date

**STATEMENT OF ACCOUNTABILITY**

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

I, \_\_\_\_\_, personally read and completed this Application/Health Statement 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 the requested personal and medical history disclosed by this applicant. I also translated and fully explained the statements above.

▶ \_\_\_\_\_  
 Signature of Translator (required) Today's Date

**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, 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 can revoke this authorization (but will be terminated from the Plan) at any time by giving written notice to CCI as long as CCI or others have not taken action relying on this authorization. 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.

Any new conditions or changes occurring after the application is submitted but prior to approval, must be reported to ConnectiCare.

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DETAILS MAY BE SUBMITTED VIA SEALED ENVELOPE MARKED "CONFIDENTIAL".

PLEASE PRINT IN INK AND COMPLETE BOTH SIDES OF FORM FOR YOU AND ANY FAMILY MEMBERS APPLYING FOR COVERAGE.					
First Name/Middle Initial/Last Name	Height (ft/in)	Weight (lbs.)	Date of Birth (mm/dd/yyyy)	Sex	Social Security #
Applicant			/ /	<input type="checkbox"/> M <input type="checkbox"/> F	_____
Spouse/Partner			/ /	<input type="checkbox"/> M <input type="checkbox"/> F	_____
Occupation Applicant	Occupation Spouse/Partner				
Dependent 1			/ /	<input type="checkbox"/> M <input type="checkbox"/> F	_____
Dependent 2			/ /	<input type="checkbox"/> M <input type="checkbox"/> F	_____
Dependent 3			/ /	<input type="checkbox"/> M <input type="checkbox"/> F	_____
Dependent 4			/ /	<input type="checkbox"/> M <input type="checkbox"/> F	_____

**ALL QUESTIONS MUST BE ANSWERED. GIVE COMPLETE DETAILS OF ANY "YES" ANSWERS.**

Has any person applying for coverage on this application, in the last 10 years, had any signs or symptoms, seen a health care provider, had treatment recommended including prescription medications, received treatment, been tested for, had the diagnosis of, or been hospitalized for any of the following conditions as stated in questions 1 through 27?

1. **Brain/Nervous** – such as: frequent and/or severe headaches, migraines, seizures, epilepsy, recurrent numbness/tingling, head injury with loss of consciousness, paralysis, stroke, memory loss, narcolepsy, use of a sleep monitoring device?  Yes  No
2. **Heart/Circulatory** – such as: chest pain, angina, heart disease, heart attack, heart murmur, valve replacement, pacemaker, defibrillator, or blood clot, phlebitis, varicose veins, rheumatic fever, Raynaud's, irregular heart beat?  Yes  No
3. **Blood/Cholesterol** – such as: high blood pressure or high cholesterol (if yes, please provide most recent reading/value), low blood pressure, blood clotting problem or bleeding disorder, anemia?  Yes \_\_\_\_\_  No
4. **Lungs/Respiratory** – such as: allergies, sinusitis, asthma, bronchitis, emphysema, sleep apnea, pneumonia, tuberculosis, difficulty breathing, shortness of breath, chronic cough, spitting/coughing up blood; use of portable oxygen?  Yes  No
5. **Digestive** – such as: infections of the mouth/throat, jaw/chewing problems, gastric reflux, frequent heartburn, ulcers, hernia, colitis, rectal bleeding, polyps, hemorrhoids, gallbladder disease including gallstones, pancreatitis, liver disease, cirrhosis, hepatitis, jaundice, unexplained weight loss?  Yes  No
6. **Urinary** – such as: kidney, bladder, urinary tract infections, stones, urinary incontinence, blood in urine, prostate problems?  Yes  No
7. **Male Reproductive System** –
  - a) Such as: infertility, low sperm count, impotence, sexual dysfunction, penile or scrotal implant, sexually transmitted disease, herpes, genital warts, undescended testes?  Yes  No
  - b) Is any male listed on this application expecting a child or in the process of adoption or surrogate pregnancy with anyone, whether or not listed on this application?  Yes  No  
If yes, name of applicant \_\_\_\_\_  
If yes, expected delivery date/date of adoption? \_\_\_\_\_

**8. Female Reproductive –**

- a) Such as: breast disorder/cyst, lump, silicone breast implants, fibroid tumors, endometriosis, pelvic pain, menstruation disorders, abnormal/absent or irregular menstrual bleeding, uterine fibroids, ovarian cysts, infertility, miscarriages, sexually transmitted disease, herpes, genital warts (HPV)?  Yes  No
- b) Does any proposed female applicant menstruate?  Yes  No  
If yes, indicate if:  Applicant/Spouse  Dependent(s)  
Dependent name(s): \_\_\_\_\_
- c) Has it been more than 40 days since her/their last menstrual period?  Yes  No  
Name(s): \_\_\_\_\_  
 Applicant/Spouse  Dependent(s)  
If yes, explain: \_\_\_\_\_
- d) Has any female applicant had a pelvic exam/Pap smear?  Yes  No  
If yes, complete 8e below.
- e) Date and result of last pelvic exam/Pap smear for each female over age 16.  
Name: \_\_\_\_\_  
Mo/Day/Yr: \_\_\_\_\_  Normal  Abnormal  
Name: \_\_\_\_\_  
Mo/Day/Yr: \_\_\_\_\_  Normal  Abnormal  
Name: \_\_\_\_\_  
Mo/Day/Yr: \_\_\_\_\_  Normal  Abnormal
- f) Is any female applicant pregnant, or in the process of adoption or surrogate pregnancy?  Yes  No  
If yes, name of applicant \_\_\_\_\_  
If yes, expected delivery date/date of adoption? \_\_\_\_\_

9. **Musculoskeletal** – such as: bone, joint and/or muscle pain, injury or disorder of joint/tendon/ligament/disc, weakness of back/spine/joint, amputation, physical handicap, polio, arthritis, gout, sprain/strain, prosthesis, joint replacement, (continued on next page)

DETAILS MAY BE SUBMITTED VIA SEALED ENVELOPE MARKED "CONFIDENTIAL".

APPLICANT NAME: \_\_\_\_\_ APPLICANT SOCIAL SECURITY # \_\_\_\_\_

**QUESTIONS, CONTINUED FROM PAGE 1. For "YES" answers, details must be provided below under the "Health History" section.**

internal fixations or hardware (i.e., pins, plates, screws), fractures, TMJ disease of the jaw, chronic back, neck, shoulder, hip, knee, hand or foot pain?  Yes  No

**10. Endocrine/Metabolic –**

- a) Such as: diabetes, thyroid disease, anemia, adrenal disorders, pituitary disorders, lupus, HIV, immune disorders, scleroderma, Epstein-Barr virus/chronic fatigue syndrome, chronic Lyme Disease?  Yes  No
- b) Is any applicant a candidate for, or a recipient of a bone marrow transplant or organ transplant, including cornea transplant?  Yes  No
- c) Is any applicant currently on the waiting list and/or registered to donate an organ or bone marrow (excluding DMV donor card)?  Yes  No

**11. Has any applicant ever had any non-malignant (benign) tumor/growth or cysts?**  Yes  No

**12. Skin Disorder/Problems –** such as: any kind of skin cancer, melanoma, psoriasis, actinic keratosis, disfiguring birthmarks, 3rd degree burns, acne, fungal infections, eczema, dermatitis, herpes, shingles, scars/keloids, or revisions of cosmetic or reconstructive surgery, chronic skin infections?  Yes  No

**13. Ears, Eyes, Nose and Throat –** Disorders such as: any infections, crossed eyes, chronic dry eye requiring treatment, glaucoma, cataracts, detached retina, polyps, deviated nasal septum, excessive snoring, problems with tonsils or adenoids, sleep apnea?  Yes  No

**14. Nervous, Mental, Emotional, Behavioral –** such as: eating disorder, anorexia/bulimia, depression, anxiety disorder, alcohol or substance use/abuse/dependency, psychological or psychiatric counseling, bi-polar, chemical imbalance, attention deficit disorder (ADD), schizophrenia, obsessive-compulsive or panic disorder?  Yes  No

**15. Congenital Abnormalities, Birth Defects –** such as: cleft lip/palate, club foot, webbed fingers or toes, mental retardation, developmental delay, Down's syndrome, heart/lung problems, skull/facial deformities, disfiguring birthmark?  Yes  No

**16. Has any applicant taken, or been advised to take, either currently or in the past 5 years any prescription medications or prescription food supplements on a long-term basis (for longer than 1 month)?** If yes, please provide the details on page 3 of the medication(s) and the reason it was prescribed.  Yes  No

**17. Cancer, of any kind –** such as: skin cancer, colon cancer, breast cancer, throat cancer, ovarian cancer, uterine cancer, prostate cancer, leukemia, Hodgkin's disease, lymphatic cancer, bone cancer, bone marrow cancer, any other cancers, tumors, or lymph node enlargement?  Yes  No

**18. Has any applicant ever been diagnosed with obesity and/or have a problem with weight control?**  Yes  No

**19. Has any applicant consulted a provider for any condition, problem or symptom(s) in the last 12 months for which a diagnosis has not yet been established?**  Yes  No

**20. Has any applicant been advised to see a dentist or oral surgeon in the last 12 months, (excluding routine checkups)?**  Yes  No

**21. Has any applicant been a patient in a hospital, clinic, surgicenter, sanatorium, or other medical facility as an inpatient or outpatient (excluding childbirth) in the last 10 years?**  Yes  No

**22. In the last 10 years, has any applicant had an abnormal physical exam, laboratory results, x-rays, EKG, MRI, CT scan, PET Scan or been advised to undergo further testing, surgery, consultation or treatment?**  Yes  No

**23. In the last 10 years, has any applicant seen, received treatment from or consulted any doctor, or any other person providing health care services for any other condition or symptom(s) not listed on this applications?**  Yes  No

**24. Has any applicant seeking coverage had health, disability, Long-term care or life insurance declined, modified, postponed or rated? If yes, please provide details on page 3.**  Yes  No

**25. Is any applicant seeking coverage currently disabled or unable to perform their normal activities, or require the use of any assistive devices including a wheelchair, walker, portable oxygen, etc.?**  Yes  No

**26. Has any applicant seeking coverage ever smoked or used tobacco? If yes, who? \_\_\_\_\_ For how long? \_\_\_\_\_ If no longer smoking/using tobacco, when was the date of the last cigarette/tobacco use? \_\_\_\_\_**

**27. Has any applicant applying for coverage had any medical problems which have not been disclosed in answer to the questions above?**  Yes  No

**28. To the best of your knowledge and belief: Have you had, been told you have by a medical professional, or have you ever been treated for Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC) or AIDS related conditions?**  Yes  No

**29. Please list all surgical procedures and date(s) of such procedures that you have had in the past 10 years.**

Name: \_\_\_\_\_

Procedure: \_\_\_\_\_

Date: \_\_\_\_\_

Name: \_\_\_\_\_

Procedure: \_\_\_\_\_

Date: \_\_\_\_\_

Name: \_\_\_\_\_

Procedure: \_\_\_\_\_

Date: \_\_\_\_\_

Name: \_\_\_\_\_

Procedure: \_\_\_\_\_

Date: \_\_\_\_\_

(continued on next page)

**QUESTIONS, CONTINUED FROM PAGE 2.**

**30.** Last doctor visit (for any reason including routine checkup) – Provide information for all applicants.

Name: \_\_\_\_\_ Reason for Visit: \_\_\_\_\_  
 Date: \_\_\_\_\_ Results: \_\_\_\_\_  
 Name: \_\_\_\_\_ Reason for Visit: \_\_\_\_\_  
 Date: \_\_\_\_\_ Results: \_\_\_\_\_  
 Name: \_\_\_\_\_ Reason for Visit: \_\_\_\_\_  
 Date: \_\_\_\_\_ Results: \_\_\_\_\_

A detailed explanation must be provided below if you answered "YES" to any question. **NOTE: Simply listing the name of a primary physician or referring to a physician's name will not be considered a substitute for listing fully detailed answers to the questions. If additional space is needed you may attach a separate page which must be signed and dated.**

**HEALTH HISTORY:**

Question Number/Ltr.	Person Affected	Condition/Diagnosis	Treatment (surgeries/medication)	Date Treatment Began	Date of Full Recovery	Physician Name, Address & Phone Number

**INSTRUCTIONS: DID YOU REMEMBER TO ...**

- Print clearly, complete all sections on front and sign at the bottom?
- Select your primary care physician and include the 6 or 8 digit Provider ID number?  
(can be found at [www.connecticare.com](http://www.connecticare.com))
- Attach the ConnectiCare Individual Health Statement?
- Attach the first month's premium payment payable to ConnectiCare?
- Attach EFT form with a check marked "Void" (if applicable), or a savings deposit slip?
- Attach proof of full-time student status for children age 19 and older?
- Attach a HIPAA Certificate of Creditable Coverage (if applicable)?
- Attach Affidavit of Domestic Partnership (if applicable)?
- Retain a signed copy for your records.

\* By my signature on Part 1, I certify that the statements made herein and in Part 1 are true and complete to the best of my knowledge and belief. Any health conditions that change after the application is submitted but prior to notice of approval, must be reported to ConnectiCare and will be considered in the final underwriting decision.

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

Note: You and any dependents aged 18 or over must sign this form along with the completed Individual application form. If we do not receive this signed form, the application will be considered incomplete and could be delayed. Further, as part of our medical underwriting, ConnectiCare may need access to medical records and other medical information. It is your responsibility to provide us access to that medical information and to pay for any costs your physician's office may charge to copy and send us those records. If we do not have complete medical information, your application will be incomplete and may be withdrawn if you do not arrange to have the medical records provided to us within sixty days of such request.

NAMES OF APPLICANT(S):	
Primary Applicant	Applicant Social Security Number
Spouse/Partner	Dependent Applicant Aged 18 or over
Dependent Applicant Aged 18 or over	Dependent Applicant Aged 18 or over

**AUTHORIZATION:**

I hereby authorize any health care provider, medical facility, pharmacy, pharmacy benefits company or pharmacy related facility, insurance or reinsurance company or employer having information about me or my minor children to provide all such information as may be requested by ConnectiCare.

This authorization includes any and all information you may have about me, including, but not limited to, information regarding diagnosis, testing, treatment and prognosis of my physical or mental condition as well as alcohol abuse treatment, drug abuse treatment, psychiatric treatment (but not psychotherapy notes), pharmacy, prescriptions, HIV testing and treatment, STD testing and treatment, lab data and EDGs. Although federal regulations require that we inform you of the potential that information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer be protected by such regulation, all information received by ConnectiCare pursuant to this authorization will be protected by federal and state privacy laws and regulations. A copy of this authorization will be valid as an original.

I understand that this authorization is required in order to enable ConnectiCare to make eligibility determinations relating to me and/or my minor children and for ConnectiCare's underwriting or risk rating determinations. If I refuse to sign or chose to revoke this authorization, ConnectiCare may refuse to consider my application for enrollment.

I understand that I may revoke this authorization at any time by notifying ConnectiCare in writing of my desire to revoke. Such revocation must be sent to the following address: ConnectiCare, Inc., Underwriting Department, 175 Scott Swamp Road, Farmington, CT 06034. Such revocation will not be valid if ConnectiCare has taken action in reliance on the authorization.

Unless an earlier date is required by law, this authorization expires upon the earliest of the following events: denial of my application, or, if insured, when I am no longer an insured of ConnectiCare.

Any health conditions that change after the application is submitted but prior to notice of approval, should be reported to ConnectiCare.

▶ _____ Signature of Primary Applicant or Representative*      Date	▶ _____ Signature of Spouse/Partner or Representative*      Date
▶ _____ Signature of Other Dependent Applicants aged 18 or over or Representative*      Date	▶ _____ Signature of Other Dependent Applicants aged 18 or over or Representative*      Date
▶ _____ Signature of Other Dependent Applicants aged 18 or over or Representative*      Date	

\* If you are the individual's representative and are not the parent or legal guardian of a minor, you must attach documentary evidence of your authority to act as the individual's representative for this authorization to be valid.

**PLEASE RETAIN A SIGNED COPY FOR YOUR RECORDS.**

<b>Please complete, sign and date the bottom of the form.</b>			
Type of Election:	<input type="checkbox"/> New Enrollment	<input type="checkbox"/> Change Bank Information	<input type="checkbox"/> Discontinue Service
First Name	Middle Initial	Last Name	
Street Address			Home Telephone Number
City	State	ZIP Code	Work Telephone Number
Financial Institution Name			
Financial Institution Street Address			
City	State	ZIP Code	
Bank Routing (ABA) and Account Number:			
Type of account:	<input type="checkbox"/> Checking	<input type="checkbox"/> Savings (must be Statement Savings; passbook savings not allowed)	
<b>AUTHORIZATION:</b>			
<p><b>Electronic Funds Transfer Authorization</b>—By completing and signing this Election of Electronic Funds Transfer Form, I authorize ConnectiCare to initiate a monthly debit entry to my account at the financial institution listed above in order to pay my monthly premium payments. I understand that the designated bank account will be debited monthly on the first of the month for which premium is due. This authorization will remain in effect until ConnectiCare has received a completed discontinuation notification (either from me or the banking institution listed above). ConnectiCare reserves the right to void this form at any time without notice. Non-payment of premium will result in termination of your policy.</p> <p><b>IMPORTANT INFORMATION:</b> If you wish to pay your premium from your checking account, please attach a check marked “void”. If you wish to pay premium from your statement savings account, please attach a deposit slip.</p> <p>Please mail this completed form, along with a voided check or savings deposit ticket, to:                  ConnectiCare, Inc. and Affiliates                  Attn: Billing/EFT                  175 Scott Swamp Road                  Farmington, CT 06032-3124</p> <p><b>New Enrollment:</b> Within ten days, we will confirm the banking information that you supplied and mail you a Confirmation of Electronic Funds Transfer. <b><u>Until you receive the Confirmation of Electronic Funds Transfer, please pay your monthly premium by submitting a check to the address on your premium payment voucher.</u></b></p> <p><b>Change/Discontinuation:</b> Any change to your banking information or discontinuation of service request should be received by ConnectiCare <i>thirty days prior to the effective date of change</i>. To change banking information or discontinue service, please submit a completed Election of Electronic Funds Transfer form with up-to-date information. This form is available on <a href="http://ConnectiCare.com/Online Forms/Member Online Forms">ConnectiCare.com/Online Forms/Member Online Forms</a> or by calling ConnectiCare’s Billing Department at 1.800.333.1733, Option #4, to request a form.</p>			

Please sign and date below. You must own the selected account. If account selected is a joint account, each joint owner must sign and date this form.

▶	▶
Applicant Signature	Joint Owner Name and Signature
Date	Date

**PLEASE RETAIN A SIGNED COPY FOR YOUR RECORDS.**



175 Scott Swamp Road  
Farmington, CT 06032  
1-800-251-7722

**BROKER AUTHORIZATION FORM\***

**Note: This authorization form is not required as part of your application for individual coverage. By completing this form, you are giving permission for your broker to access your personal health information for purposes of checking the status of your application.**

I, \_\_\_\_\_ hereby authorize ConnectiCare and its affiliates, its employees and agents (collectively "ConnectiCare"), to release to RON GAMBARDIELLA [Insert full name of broker/agency] my and/or my dependents' (those who are applying for coverage) personal health information maintained by ConnectiCare (e.g., information relating to the diagnosis, treatment, claims information, and health care services provided or to be provided and which identifies either name, address, social security number, Member ID number) **except** the following information about me: \_\_\_\_\_ [DESCRIBE INFORMATION NOT TO BE DISCLOSED, IF ANY] for the purpose of assisting me in my application for individual insurance coverage with ConnectiCare. .

I understand that any personal health information or other information released to the broker/agency identified above may be subject to redisclosure by such broker/agency and may no longer be protected by applicable federal and state privacy laws.

This authorization is valid from the date of my/my representative's signature below and shall expire the earlier of \_\_\_\_\_ [INSERT DATE/EVENT UPON WHICH THIS AUTHORIZATION EXPIRES] or the date upon which ConnectiCare has made a determination with respect to my application for coverage. I understand that I have a right to revoke this authorization by providing written notice to ConnectiCare. However, this authorization may not be revoked if ConnectiCare, it's employees or agents have taken action on this authorization prior to receiving my written notice. I also understand that I have a right to have a copy of this authorization.

I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my eligibility for benefits or enrollment in an individual plan.

ConnectiCare

Broker Authorization Form

Page 2

Name of Applicant: \_\_\_\_\_

I have discussed the terms of this authorization with my spouse and competent adult dependents, and have obtained their consent to these terms.

Name of Applicant: \_\_\_\_\_

Signature of Applicant: \_\_\_\_\_

Date: \_\_\_\_\_

**If applicable, Legal Representatives (including parent/guardian of a minor child) sign below:**

*By signing this form, I represent that I am the legal representative of the Applicant identified above and will provide written proof (e.g., Power of Attorney, living will, guardianship papers, etc.) that I am legally authorized to act on the Member's behalf with respect to this authorization form.*

Name of Legal Representative : \_\_\_\_\_

Signature of Legal Representative: \_\_\_\_\_

Relationship to Applicant: \_\_\_\_\_

Date: \_\_\_\_\_

Name of Witness: \_\_\_\_\_

Signature of Witness: \_\_\_\_\_