SOLO Individual Application/Change Form

ConnectiCare, Inc.
ConnectiCare Insurance Company, Inc.

Thank you for your interest in SOLO Individual Health Insurance. ConnectiCare's award winning customer service begins with helping you find the plan that best fits your needs. There are several ways to enroll:

Apply Using a Broker
After discussions with your broker, an e-mail invitation will be sent to you that will provide detailed instructions about the plan and online enrollment process.

Apply Directly Online
Go to www.connecticare.com/solo to obtain a quote and apply for a medical plan that meets your needs. Applying online is faster and environmentally friendly.

Apply Using a Paper Application
- Complete, sign and date the Individual Application/Change Form no more than 60 days prior to the requested effective date.
- For applicants under the age of 18, a parent or guardian must sign and date the application form.
- Mail applications to:

ConnectiCare, Inc. and Affiliates
175 Scott Swamp Road
Farmington, CT 06032

Eligibility Period

Open Enrollment:
For 2015, the annual open enrollment period will be November 15, 2014, through February 15, 2015.

2015 Open Enrollment Period	
Open Enrollment	**Coverage Effective Dates**
If enrolled November 15, 2014 – December 15, 2014	Coverage effective January 1, 2015
If enrolled December 16, 2014 – January 15, 2015	Coverage effective February 1, 2015
If enrolled January 16, 2015 – February 15, 2015	Coverage effective March 1, 2015

Limited Open Enrollment:
Insurers offering individual products must provide a limited open enrollment period for the following qualifying events:
- An individual and/or any dependents lose minimum essential coverage 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 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)

- New coverage becomes available to an individual or enrollee that has permanently moved into the ConnectiCare service area
- 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
- 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

Initial Premium Payment:
Initial premium payment is required with the submission of the application in order to obtain medical coverage. ConnectiCare offers the following payment options:

Online Application Submissions:
- Electronic Funds Transfer (EFT) from your bank account
- Credit Card

Paper Application Submissions:
- EFT
- Credit Card
- Live Check or Money Order
- Mail payments to:

ConnectiCare, Inc. and Affiliates
175 Scott Swamp Road
Farmington, CT 06032
Attention: Billing Department

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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 ☐ Add Dependent ☐ Change Ind. Plan Choice (select new choice below) ☐ Qualifying event ☐ Other (Name change, address change, etc.) _____

Effective Date (mm/dd/yyyy) / /

Marital Status: ☐ Single ☐ Married (Civil Union) ☐ Legally Separated ☐ Separated ☐ Widowed ☐ Divorced ☐ Domestic Partnership (include "Affidavit of Domestic Partnership")

E-mail Address

Street Address

Primary Telephone Number ☐ Home ☐ Cell ☐ Work

City State Zip Code

Secondary Telephone Number ☐ Home ☐ Cell ☐ Work

P.O. Box/Billing Address (if applicable) City State Zip Code

AGENT SECTION:

Agency Name	Phone Number
Agent Name (Print)	Agent Signature ▶

MEMBER(S): First Name/Middle Initial/Last Name	Add	Delete	Social Security Number or Current Member Identification Number	Gender	Date of Birth (mm/dd/yyyy)
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.					
Applicant	☐	☐	– –	☐ M ☐ F	
Tobacco: Within the last 6 months have you used tobacco on average of four or more times a week ☐ Yes ☐ No					
☐ White ☐ Black/African American ☐ Hispanic/Latino ☐ Asian ☐ Amer. Indian/Alaska Native ☐ Native Hawaiian/Pacific Islander ☐ Other ☐ Unknown					
Spouse/Civil Union/Domestic Partner	☐	☐	– –	☐ M ☐ F	
Tobacco: Within the last 6 months have you used tobacco on average of four or more times a week ☐ Yes ☐ No					
☐ White ☐ Black/African American ☐ Hispanic/Latino ☐ Asian ☐ Amer. Indian/Alaska Native ☐ Native Hawaiian/Pacific Islander ☐ Other ☐ Unknown					
Dependent 1	☐	☐	– –	☐ M ☐ F	
Tobacco: Within the last 6 months have you used tobacco on average of four or more times a week ☐ Yes ☐ No					
☐ White ☐ Black/African American ☐ Hispanic/Latino ☐ Asian ☐ Amer. Indian/Alaska Native ☐ Native Hawaiian/Pacific Islander ☐ Other ☐ Unknown					
Dependent 2	☐	☐	– –	☐ M ☐ F	
Tobacco: Within the last 6 months have you used tobacco on average of four or more times a week ☐ Yes ☐ No					
☐ White ☐ Black/African American ☐ Hispanic/Latino ☐ Asian ☐ Amer. Indian/Alaska Native ☐ Native Hawaiian/Pacific Islander ☐ Other ☐ Unknown					
Dependent 3	☐	☐	– –	☐ M ☐ F	
Tobacco: Within the last 6 months have you used tobacco on average of four or more times a week ☐ Yes ☐ No					
☐ White ☐ Black/African American ☐ Hispanic/Latino ☐ Asian ☐ Amer. Indian/Alaska Native ☐ Native Hawaiian/Pacific Islander ☐ Other ☐ Unknown					

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

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ConnectiCare, Inc.
ConnectiCare Insurance Company, Inc.

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

POS Benefit Plans – In-Network Deductible=Individual/Family (Select one)

☐ POS Deductible $2,500/$5,000 – **F**	☐ POS Upfront Deductible $500/$1,000 – **F**	☐ POS Upfront Deductible $1,500/$3,000–30PCP–50%–**F**
☐ POS Deductible $5,000/$10,000 – **F**	☐ POS Upfront Deductible $750/$1,500 –**F**	☐ POS Upfront Deductible $2,500/$5,000-30PCP–50%–**F**
☐ POS Upfront Deductible $1,500/$3,000-20% – **F**	☐ POS Upfront Deductible $1,000/$2,000 - **F**	☐ POS Upfront Deductible $5,000/$10,000–30PCP–50%-**F**
☐ POS Upfront Deductible $2,500/$5,000 – 20% – **F**	☐ POS Upfront Deductible $2,500/$5,000 – **F**	☐ POS Copay and Deductible $5,000/$10,000 – 20% – **F**

Pharmacy: Included in all plan options	**Adult Dental:** ☐ $25 Deductible, 100%/0%/0%, unlimited max, no ortho

HSA Compatible Plans Deductible=Individual/Family:

☐ POS HDHP $1,500/$3,000 Deductible – **F**	☐ POS HDHP $3,000/$6,000 Deductible – **F**	☐ HMO HDHP $5,000/$10,000 Deductible – **F**
☐ POS HDHP $2,000/$4,000 Deductible – **F**	☐ POS HDHP $5,000/$10,000 Combined Deductible – **F**	

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.

Would you like to open an account with Health Equity? ☐ Yes ☐ No

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 and the initial premium do not give me immediate coverage; (2) the broker is only authorized to submit this application and the initial premium payment; (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.

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

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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 2013 for ConnectiCare, Inc. (CCI): 84.8%
- Federal Medical Loss Ratio for calendar year 2013 for ConnectiCare, Inc. (CCI):

Individual	99.4%
Small-Group	81.4%
Large-Group	85.7%

- State Medical Loss Ratio for calendar year 2013 for ConnectiCare Insurance Company, Inc. (CICI): 78.9%
- Federal Medical Loss Ratio for calendar year 2013 for ConnectiCare Insurance Company, Inc. (CICI):

Individual	83.1%
Small-Group	80.3%
Large-Group	88.3%

FOR BUSINESS USE ONLY:	
Date Received:	Date Processed:
Date Audited:	Account Number:

SOLO Election of Electronic Funds Transfer Form for Monthly Premium Withdraw*

ConnectiCare, Inc.
ConnectiCare Insurance Company, Inc.

Please complete, sign and date the bottom of the form	**Policy Number (Required)**

Type of Election: ☐ New Enrollment ☐ Change Bank Information ☐ 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 (ABA) Routing Number	Account Number

Type of Account: ☐ Checking ☐ Savings (Must be a Statement Savings; passbook savings not allowed)

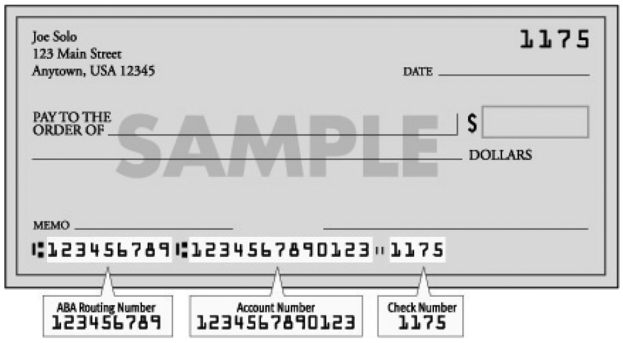
AUTHORIZATION:

Electronic Funds Transfer Authorization: By completing and signing this Election of Electronic Funds Transfer Form for Monthly Premium Withdrawal, you authorize ConnectiCare to initiate a monthly debit entry to your account at the financial institution listed above in order to pay your monthly premium payments. You understand that once this ConnectiCare EFT application is processed, the designated bank account will be debited monthly on the first of the month for which the premium is due. ***Note: If you are completing this form as part of your insurance application, your first payment will be debited up to 10 business days prior to your effective date, and all premiums from the date of approval back to the effective date will be debited. This could mean that, initially, you may owe more than one month of premium.*** Once ConnectiCare has confirmed your banking information and has activated your electronic funds transfer, your monthly invoice will be accessible online only at www.connecticare.com in a secure, user-friendly environment. This authorization will remain in effect until ConnectiCare has received a complete discontinuation notification (either from you 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.

IMPORTANT INFORMATION: 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.

Please send 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 06034-4050
Fax: (860) 678-5255 **(Include EFT and your Policy Number in subject line.)**



Change/Discontinuation: Any change to your banking information or discontinuation of service request should be received by ConnectiCare **30 days prior to the effective date of change**. ***Please be advised that if ConnectiCare receives your notification to discontinue electronic funds transfer less than 30 days in advance, including terminating your policy with ConnectiCare, your bank account may be debited for the upcoming monthly premium.*** *Your premium will be refunded to you through a check to your billing mailing address 4 to 6 weeks following the date of the withdrawal.* To change banking information or discontinue service, please submit a completed Election of Electronic Funds Transfer Form for Monthly Premium Withdraw with up-to-date information.

* This form is for direct commercial SOLO plans only.

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.

▶ Signature	Date	▶ Joint Owner Name and Signature	Date

PLEASE RETAIN A SIGNED COPY FOR YOUR RECORDS.

EFT 09/14

Credit Card Application Form

ConnectiCare, Inc.
ConnectiCare Insurance Company, Inc.

Please complete, sign and date the bottom of the form. This credit card payment is for the initial month of premium only.

CONNECTICARE® SOLO APPLICANT INFORMATION:

First Name | Middle Initial | Last Name

Street Address | Home Telephone Number ( )

City | State | ZIP Code | Work Telephone Number ( )

E-mail Address (optional — used for payment confirmation) @

CREDIT CARD INFORMATION:

Credit Card Type ☐ VISA ☐ MasterCard ☐ Discover Card

Cardholder's Name (exactly as it appears on the card)

Credit Card Billing Address (exactly as it appears on your credit card statement) ☐ Same address as above
Street Address | City | State | ZIP Code

Credit Card Account Number | Security Code | Card Expiration Date ____ / ____ (mm / yy)

CREDIT CARD AUTHORIZATION:

By completing and signing this Election of Credit Card Payment Form, I authorize ConnectiCare to initiate a transaction to the credit card listed above in order to pay my initial premium.

IMPORTANT INFORMATION: This credit card payment is for the initial month of premium only. You will receive a monthly premium invoice starting the second month after your policy begins. To continue to pay by credit card, you must register at the "ConnectiCare® SOLO" section on www.connecticare.com and initiate the transaction each month. No charge will be made against your credit card unless your application for individual health insurance is approved by ConnectiCare.

Please sign and date below. You must own the selected account.

▶ _____ _____

Cardholder's Signature | Date

PLEASE RETAIN A SIGNED COPY FOR YOUR RECORDS.
INCLUDE ORIGINAL WITH YOUR CONNECTICARE® SOLO APPLICATION.

ConnectiCare® SOLO plans are available to individuals only and are not available to employer groups.

CCP 0913