



For help or assistance
Call 1- 866- 508-0618

How to Enroll with Connecticare Health Care Plans

Connecticare Insurance can refuse to insure you based on your health application. Before you spend your time filling out an enrollment application, take a few minutes to call us. We can spot some health conditions you may have that Connecticare will reject. After talking with us, we then recommend you fill out all the forms and mail your application to us. We will review your forms for missing information and will help you get insurance with Connecticare. Our toll free phone number is: 1-866-508-0618. If the lines are busy, leave your name, phone number and a short message and we will get back to you shortly.

1. Complete and sign the application/change form (part 1). Be sure to select a primary care physician. This form is to choose your doctor. The easiest way is to call your doctor and get his PCP number.

Part 1. Enrollment Application

2. Answer all questions on the Individual Health Statement (part 2). Be sure to answer the questions for all family members applying for medical coverage with Connecticare.

Part 2. Individual Health Statement

3. Complete and sign the Underwriting Authorization (part 3).

Part 3. Underwriting Authorization

4. You do not have to submit your first month premium with your application. The effective date will be the 1st of the month following receipt of a complete application and acceptance by Connecticare. If you do not submit the premium, You may owe more than 1 month premium. We recommend sending 1 month premium with application.

Please make a check payable to Connecticare.

If you want to pay Connecticare directly from your bank in the future, fill out the Electronic Funds Transfer Form.

Optional: Electronic Funds Form

If you would like us to call on your behalf and help you get health insurance, sign this form. This allows Connecticare to talk with us about your personal health information and to help you get the policy issued.

Optional: Broker Authorization Form

5. Send all the forms and paperwork to:

**Creative Health Insurance
230 Hartford Turnpike Ste 26
Vernon, Ct. 06066**

There is no charge for using Creative Health Insurance. The price of health insurance in Connecticut is fixed by law - you cannot find a better price anywhere for the same product. The insurance companies will pay us commissions to help you find the best medical plan for you and your family.

Sometimes we are able to find you the plan you wanted at a lower price. This is not because we have special prices. We can do this because we specialize in health insurance here in Connecticut. We do not handle auto insurance, or financial products. We are not employees of an insurance company. We are here to help you with your health care needs. . . . Robin Thomas Dubord AAI - Creative Health Insurance

Z 12-09-2009

1. Complete, sign and date the Individual Application/Change Form -PART 1 -no more than 60 days prior to the requested effective date. Be sure to:
 - a. Check the box for the medical plan being selected.
 - b. Check the boxes for the pharmacy co-pay and annual maximum that is being selected. (does not apply to HDHP plans)
2. Accurately and completely answer all questions on the Individual Health Statement -PART 2 -for each family member applying for coverage. If the applicant knowingly provides false information and/or omits information on the application or health statement and such information submitted or omitted materially affects the risk assumed by Connecticare, Connecticare will seek to have the policy rescinded.
3. Complete, sign and date the Underwriting Authorization Form -PART 3.
4. For dependent applicants under the age of] 8, the application must have a parent/guardian's signature and date -and the parent/guardian's full name must be printed on the application. Dependent applicants age 18 and over must sign and date the application themselves.
5. All completed forms must be signed, dated and received at Connecticare by the last day of the month for an effective date on the 1st of the next month. (EX. A complete application received by January 31st would be eligible for a February 1st effective date. A complete application received on February 1st would be eligible for a March 1st effective date. (Please note that if the application is approved in these scenarios, at least 2 months of premium will be due right away.)
6. You do not have to submit your first premium payment with your application. However, Once you are approved, all premiums from the effective date of coverage are due by the first of the month following the date of their approval letter, or the effective date of the policy, if later. This could mean that you could owe more than one month of premium and owe the premium quickly. We recommend you submit 1 month's premium but it is your choice.
- 6a. When paying your premium via Electronic Funds Transfer, EFT, you can sign up for EFT along with your initial application. All you have to do is complete the EFT form and attach a voided check with your application, and sign and Form 4 - Be sure to include a check marked "Void".
7. If applicable, complete the Domestic Partner Form and include certification.
8. If you would like us to call on your behalf and help you get health insurance, sign this form. This allows Connecticare to talk with us about your personal health information and to help you. All applicants age 18 and older must sign this form if they wish to have us, the broker receive their personal health information.
9. Effective dates for coverage are the first of the month following the date Connecticare receives your complete application. Acceptance into the plan is based on Connecticare's review of your individual Health Statement(s) and the applicant s meeting the eligibility requirements and underwriting criteria. As part of medical underwriting, Connecticare may need access your medical records and other medical information. It is your responsibility to provide access to that medical information and to pay for any costs your physician's office may charge to copy and send Connecticare those records. If Connecticare does not have complete medical information within 45 days of the request, your application will be incomplete, and will be withdrawn. Many doctors do not charge and will fax to the company.

For help or questions call Creative Health Insurance in Connecticut 860-647-7353 or 1-866-508-0618

XX

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

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 (include "Statement of Domestic Partnership")		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 **A Plans** – Waive the In-Network Upfront Plan Deductible on Limited Preventive Care Services **B Plans** – All services – including Preventive Care – apply to the Plan Deductible

<p>POS Benefit Plans (Select one) (In-Network Deductible=Individ./Family):</p> <p><input type="checkbox"/> POS Hospital Deductible \$2,500/\$5,000 <input type="checkbox"/> POS Hospital Deductible \$5,000/\$10,000 <input type="checkbox"/> POS Upfront Deductible \$500/\$1,000 – A <input type="checkbox"/> POS Upfront Deductible \$750/\$1,500 – B <input type="checkbox"/> POS Upfront Deductible \$1,500/\$3,000 – 20% – B <input type="checkbox"/> POS Upfront Deductible \$2,000/\$4,000 – A <input type="checkbox"/> POS Upfront Deductible \$2,500/\$5,000 – B <input type="checkbox"/> POS Upfront Deductible \$2,500/\$5,000 – 20% – B <input type="checkbox"/> POS Upfront Deductible \$10,000 Combined – B</p> <p>Pharmacy Co-Pay (Select one):</p> <p><input type="checkbox"/> \$10 / 50% / 50% \$1,000 Benefit Maximum <input type="checkbox"/> No RX <input type="checkbox"/> \$10 / 50% / 50% \$5,000 Benefit Maximum</p>	OR	<p>HSA Compatible Plans (Select one HMO plan or POS plan) (Deductible=Individual/Family):</p> <p>HMO HDHP <input type="checkbox"/> \$5,000/\$10,000 Deductible – A</p> <p>POS HDHP <input type="checkbox"/> \$1,500/\$3,000 Deductible – 30/45 – B <input type="checkbox"/> \$2,000/\$4,000 Deductible – 20% – A <input type="checkbox"/> \$3,000/\$6,000 Deductible – 30/45 – A <input type="checkbox"/> \$3,000/\$6,000 Deductible – 30/45 – B <input type="checkbox"/> \$5,000/\$10,000 Deductible – A <input type="checkbox"/> \$5,000/\$10,000 Deductible – B</p>
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MEMBER(S): First Name/Middle Initial/Last Name	Add	Delete	Social Security Number or Current Member Identification Number	Sex	Date of Birth (mm/dd/yy)	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/Civil Union/Domestic 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
Dependent 2			_____	<input type="checkbox"/> M <input type="checkbox"/> F	/ /		_____	<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

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.

Employee:
 White Black/African American Hispanic/Latino Asian Amer. Indian/Alaska Native Native Hawaiian/Pacific Islander Other Unknown

Spouse/Civil Union/Domestic Partner:
 White Black/African American Hispanic/Latino Asian Amer. Indian/Alaska Native Native Hawaiian/Pacific Islander Other Unknown

Dependent 1:
 White Black/African American Hispanic/Latino Asian Amer. Indian/Alaska Native Native Hawaiian/Pacific Islander Other Unknown

Dependent 2:
 White Black/African American Hispanic/Latino Asian Amer. Indian/Alaska Native Native Hawaiian/Pacific Islander Other Unknown

Dependent 3:
 White Black/African American Hispanic/Latino Asian Amer. Indian/Alaska Native Native Hawaiian/Pacific Islander Other Unknown

Tell us about your other insurance: Do you have any other health insurance policy or certificate in force? Yes No

Name of other insurance company _____	Type of coverage <input type="checkbox"/> Group <input type="checkbox"/> Individual	Last date of coverage _____
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Do you intend to replace your current medical or health policy with this policy? Yes No

AGENT SECTION:	
Agency Name Creative Health Insurance 860-647-7353	Phone Number
Agent Name (Print) Robin Dubord	Agent Signature

FOR BUSINESS USE ONLY:	
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)
▶ Spouse/Partner Signature (if applicable)	Date	▶ Dependent Signature (age 18 years-over)
		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
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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, 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.

IF YOU ANSWER "YES" TO ANY QUESTION, YOU MUST PROVIDE COMPLETE DETAILS IN THE HEALTH HISTORY SECTION.

APPLICANT NAME: _____ APPLICANT SOCIAL SECURITY # _____

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

14. 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

15. Male Reproductive System (all men must respond)

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) Are you expecting a child or in the process of adoption or surrogate pregnancy with anyone, whether or not listed on this application? If yes, please provide the expected delivery/adoption date: _____ Yes No

16. Female Reproductive – (all females between ages 10-55 must respond)

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 treatment/services, 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/Partner _____ Dependent(s)
Name(s): _____

c) Has it been more than 40 days since her/their last menstrual period? Yes No
Name(s): _____ Applicant _____ Spouse/Partner _____ Dependent(s)
If yes, explain: _____

d) Has any female applicant over age 16 had a pelvic exam/Pap smear? Yes No
If yes, provide the date and result of the last pelvic exam/Pap smear: Name(s): _____
Mo/Day/Yr: _____ Normal _____ Abnormal _____

e) Is any female applicant pregnant, or in the process of adoption or surrogate pregnancy? Yes No
If yes, please provide the expected delivery/adoption date: _____

17. In the last 10 years, has any applicant:

a. ever been a candidate for, or a recipient of a bone marrow transplant or organ transplant, including cornea transplant? Yes No

b. been placed on a waiting list and/or registered to donate an organ or bone marrow (excluding DMV donor card)? Yes No

c. ever had any non-malignant (benign) tumor/growth or cysts? Yes No

d. ever been diagnosed with obesity and/or have a problem with weight control? Yes No

e. been a patient in a hospital, clinic, surgicenter, or other medical facility as an inpatient or outpatient (excluding childbirth)? Yes No

f. had health, disability, long-term care or life insurance declined, modified, postponed or rated? Yes No

g. been 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

h. been told by a medical professional, or ever been treated for Acquired Immune Deficiency Syndrome (AIDS), AIDS-Related Complex (ARC) or AIDS-related conditions? Yes No

i. ever smoked or used tobacco? Yes No
If yes, who and for how long? _____
If no longer smoking/using tobacco, date of last cigarette/tobacco use? _____

j. had an abnormal physical exam, laboratory results, X-rays, EKG, MRI, CT Scan, PET Scan, ultrasound, cardiac testing, or been advised to undergo further testing, surgery, consultation or treatment? Yes No

k. had any surgical procedures? Yes No

18. In the past 5 years has any applicant taken, or been advised to take, any prescription medications or prescription food supplements on a long-term basis (for longer than 1 month)? Yes No

19. In the past 12 months has any applicant been advised to see a dentist or oral surgeon (excluding routine checkups)? Yes No

20. Has any applicant applying for coverage had any medical problems which have not been disclosed on this Health Statement? Yes No

IF YOU ANSWER "YES" TO ANY QUESTION, YOU MUST PROVIDE COMPLETE DETAILS IN THE HEALTH HISTORY SECTION.

(continued on next page)

APPLICANT NAME: _____ APPLICANT SOCIAL SECURITY # _____

QUESTIONS, CONTINUED FROM PAGE 2.

21. In the past 12 months has anyone been treated for any injuries? If so, please provide date of injury, first date of treatment, recovery date and detail of injury/accident. Yes No

22. Last doctor visit for any reason, including routine checkup in the last 3 years (excluding dental or eye exam). Provide information for all applicants.

Name	Reason For Visit	Date of visit	Results	Physician
Applicant				
Spouse/Partner				
Dependent 1				
Dependent 2				
Dependent 3				
Dependent 4				

A detailed explanation must be provided below if you answered "YES" to any question (1-21). NOTE: Simply listing the name of a primary physician or referring to a physician's name will be 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, and sign and date the application and underwriting authorization form (ages 18 and older)
- Select your primary care physician and include the 6- or 8-digit Provider ID number?
(It can be found at www.connecticare.com – click "Find a Doctor.")
- Attach EFT form with a check marked "Void" (if applicable), or a savings deposit slip?
- Attach Domestic Partner Verification Form or other satisfactory certification as we determine (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:	
<p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>Any health conditions that change after the application is submitted but prior to notice of approval, should be reported to ConnectiCare.</p>	
▶ _____ 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.



175 Scott Swamp Road
Farmington, CT 06034
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. All applicants over age 18 may sign the same copy of this form. However, if you prefer, each applicant over age 18 may sign his or her own copy.

I, _____ hereby authorize ConnectiCare and its affiliates, its employees and agents (collectively “ConnectiCare”), to release to _____ **Creative Health Insurance** [Insert full name of broker/agency] my and/or my dependents’ (those who are under the age of 18 and 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 includes either name, address, social security number, or Member ID number) except the following information:

_____ [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, its 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: _____

Signature of Applicant: _____

Date: _____

Name of Applicant: _____

Signature of Applicant: _____

Date: _____

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 below and will provide written proof (e.g., Power of Attorney, guardianship papers, etc.) that I am legally authorized to act on the Applicant's behalf with respect to this authorization form.

Name of Applicant: _____

Name of Legal Representative: _____

Signature of Legal Representative: _____

Relationship to Applicant: _____

Date: _____