Connecticut Partnership Plan 2.0

Enrollment Form

New Enrollee:	X
Change of Name:	
Change of Address:	
Termination:	
Add Dependent:	
Term Dependent:	

TRUMBULL
PUBLIC SCHOOLS

EMPLOYER	TRUMBULL BOARD OF EDUCATION	EMPLOYEE NO.	
EMPLOYEE NAME (Last, First)		GROUP	
Home Street Address		DATE OF HIRE	
City, State & Zip		EFFECTIVE DATE	
Phone No. (Home)		(1st day of following mo. after DOH & last day of mo. for term)	
Phone No. (Cell)		EMAIL	

COVERAGE ELECTIONS:	Medical/RX	Dental
Employee Only		
Employee and Dependant		
Family		
COBRA/Retiree		
Decline Coverage		

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

MEDICARE ELIGIBLE COVERAGE ELECTIONS:	*	MEDICAL	DENTAL
	Part A		
	Part B		

* RETIREES ONLY

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.

UnitedHealthcare® Oxford

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