POSTDOCTORAL RESEARCH ASSOCIATE HEALTH ENROLLMENT/CHANGE FORM

CO-744P REV. 4.2021

State Of Connecticut
Office of the State Comptroller
https://carecompass.ct.gov

Type or print and forward to your Agency HR

You only need to complete and submit this form to Human Resources if you are wishing to make a coverage update.

① Your Personal Information

Last Name	First Name, MI	Agency	Employee Number
		UConn	

Street Address	City	State	Zip Code

Date of Birth (MM/DD/YYYY)	Gender (M/F)	Home Telephone Number

Email Address	Cell/Mobile Telephone Number

② Application Type

☒ Annual Open Enrollment

③ Choose Medical Plan – Select Only One Choice.

Note that your choices will remain in effect throughout this plan year (9/1/24 – 8/31/25) unless you experience a change in family status. Please keep a copy of this form for your records.

☐ No Change – Keep Current Medical Coverage Election

☐ Waive/Cancel Medical and Prescription Coverage

Change Coverage to:

☐ Anthem CT Partnership Plan

④ Choose Your Dental Plan Select Only One Choice.

Note that your choices will remain in effect throughout this plan year (7/1/24 – 6/30/25) unless you experience a change in family status. Please keep a copy of this form for your records.

☐ No Change – Keep Current Dental Coverage Election

☐ Waive/Cancel Dental Coverage

Change Coverage to:

☐ Basic Dental Plan
☐ Enhanced Dental Plan
☐ Total Care DHMO Plan
☐ Dental HMO Plan

⑤ Spouse/Dependent Information List ONLY the dependent(s) that you wish to add or drop to this year's health coverage.

Dependents currently covered will remain covered unless you elect to add or drop them. See eligibility rules on https://carecompass.ct.gov for required documentation.

Name	Relationship	Gender	Date of Birth	Social Security Number	Medical		Dental	
					Add	Drop	Add	Drop
					☐	☐	☐	☐
					☐	☐	☐	☐
					☐	☐	☐	☐
					☐	☐	☐	☐

☐ FLES rate request – If you are enrolling at least one child, your spouse is also an active State of Connecticut employee, and they are enrolled in the same health plan under their own record as Employee Only, you may be eligible for the Family Less Employed Spouse (FLES) rate. Your agency HR/Payroll office will contact you for verification of your spouse's enrollment. **FLES available for Dental Only**.

⑥ Signature & Authorization

I hereby apply for membership in the plan(s) above. I understand that if I am changing plans, my current coverage will be canceled when my new coverage takes effect. I understand that the services may be subject to exclusions, limitations, and conditions described by the health plan.

I certify that all information on this form is correct to the best of my knowledge and belief. I understand that providing false and/or incomplete information may result in the loss of coverage and/or nonpayment of claims for me or any ineligible enrollee(s). It is my responsibility to notify my HR / Payroll Agency when a dependent becomes ineligible.

I hereby authorize the State Comptroller to make deductions, if applicable, from my paycheck and/or bill me as necessary for the medical and/or dental insurance indicated above.

Signature	Date