Connecticut Partnership Plan
Add / Term / Change Form

New Enrollee:	☐
Name Change:	☐
Address Change:	☐
Termination:	☐
Add Dependent:	☐
Terminate Dependent:	☐

FAIRFIELD PUBLIC SCHOOLS

EMPLOYER	FAIRFIELD PUBLIC SCHOOLS
EMPLOYEE NAME (LAST, FIRST)	
EMPLOYEE'S HOME ADDRESS	
CITY, STATE & ZIP	
DATE OF HIRE	
EFFECTIVE DATE (1st day of a month for new enrollment & last day of a month for termination)	

COVERAGE ELECTIONS

	Name (Last, First)	*Date of Birth*	*Social Security Number*	*Gender*	*Med/Rx*	*Dental*
EMPLOYEE						
DEPENDENT (Spouse)						
DEPENDENT (Child)						
DEPENDENT (Child)						
DEPENDENT (Child)						
DEPENDENT (Child)						
DEPENDENT (Child)						
DEPENDENT (Child)						

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. In the case of non-compliance or non-participation in HEP, the $100 monthly premium cost increase shall be recouped by the district through payroll deduction.

UnitedHealthcare Oxford

OFFICE of the STATE COMPTROLLER