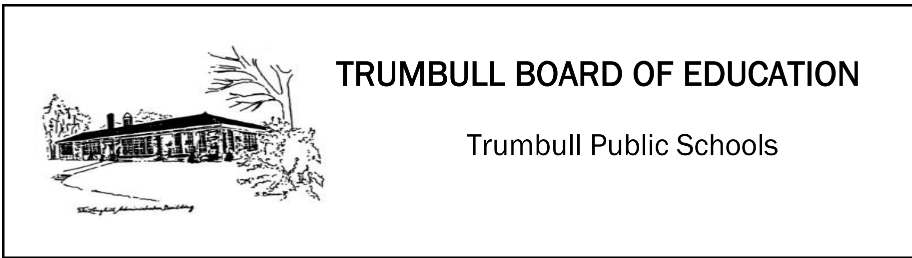
Connecticut Partnership Plan 2.0
Enrollment / Change Form

New Enrollee	☐
Change of Name	☐
Change of Address	☐
Termination	☐
Add Dependent	☐
Term Dependent	☐



TRUMBULL BOARD OF EDUCATION

Trumbull Public Schools

EMPLOYEE NAME (Last, First)		EFFECTIVE DATE	7/1/2017
Home Street Address		EMPLOYEE NO.	
City, State & Zip		GROUP	
Phone No. (Home)		DATE OF HIRE	
Phone No. (Cell)			

Preferred # (Check one) Home ☐ Cell ☐ EMAIL

COVERAGE ELECTIONS:	Medical/RX	Dental
EMPLOYEE ONLY	☐	☐
EMPLOYEE & DEPENDENT	☐	☐
FAMILY	☐	☐
RETIREE/RETIREE SPOUSE	☐	☐
DECLINE COVERAGE *	☐	☐

* If declining Medical and/or Dental coverage you must complete the info below (Name, DOB) for all eligible dependents if you are entitled to a Health Ins. Waiver

Notes: For Payroll & Insurance Use only

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

MEDICARE ELIGIBLITY ELECTIONS: Part A ☐ Part B ☐ RETIREES ONLY

EMPLOYEE SIGNATURE: ______________________ DATE: __________

By signing this CT Partnership Plan 2.0 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.