HEALTH ENHANCEMENT PROGRAM OPT-OUT

CO-1316 REV. 3/2024

State of Connecticut
Office of the State Comptroller Healthcare
Policy & Benefit Services Division
165 Capitol Ave.
Hartford, CT 06106-1775
carecompass.ct.gov

TYPE OR PRINT AND FORWARD TO YOUR AGENCY PAYROLL/HUMAN RESOURCES OFFICE. THIS FORM IS ONLY VALID FOR USE DURING THE FIRST 31 DAYS OF HIRE, OR THE ANNUAL OPEN ENROLLMENT PERIOD.

EMPLOYEE LAST NAME	EMPLOYEE FIRST NAME, MI	EMPLOYEE ID	DATE OF BIRTH

HOME/CELL PHONE NUMBER (Required) Phone number is required but will only be used for interacting with your medical insurance carrier for health-related info. For privacy reasons do not use your work phone number.	**EMAIL ADDRESS** Do not use your work email address. Provide an email address if you want a confirmation of your enrollment.

HEALTH ENHANCEMENT PROGRAM DESCRIPTION

This program is designed to enhance the ability of patients with their doctors to make the most informed decisions about staying healthy, and, if you have one of the five listed conditions in the 2011 SEBAC Agreement, to treat their illness. As is currently the case under the State Health Plan, any medical decisions will continue to be made by the patient and his or her physician.

For additional information on the plan, be sure to review the 2011 SEBAC Agreement document.

☐ I do NOT elect to participate at this time. I understand I will ONLY have the opportunity to enroll in the Health Enhancement Program during the annual Open Enrollment period.

CONSENT TO DECLINE PARTICIPATION

I agree that by electing to not participate in the State of Connecticut Health Enhancement Program sponsored by my employer, the State of Connecticut, I am electing to be responsible for higher premium co-shares of $100 per month, a $350 deductible per participant per year, and would be ineligible for reductions in the co-pays for certain prescriptions and office visits. I recognize that I am required to sign this authorization as a condition of my non-participation in the Health Enhancement Program.

I accept the terms of this Health Enhancement Program Opt-Out form.

Agency Personnel: Send the completed form to OSC.CTHEP@ct.gov or fax to: (860)-702-3556.

EMPLOYEE SIGNATURE	DATE

THIS SECTION TO BE COMPLETED BY AUTHORIZED AGENCY PERSONNEL			
Is this employee currently enrolled in or eligible for a state-sponsored Medical or Dental?	☐	YES	☐ NO
Employing Agency:	Agency Telephone Number:		
Preparer's Name:	Preparer's Signature:		
(Print Name of Authorized Agency Employee)			