HEALTH ENHANCEMENT PROGRAM ENROLLMENT

CO-1314 REV. 5/2023

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

TYPE OR PRINT AND FORWARD TO YOUR AGENCY PAYROLL/HUMAN RESOURCES OFFICE

EMPLOYEE LAST NAME	EMPLOYEE FIRST NAME, MI	SOCIAL SECURITY # XXX-XX-	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 elect to participate in the Health Enhancement Program. I understand I must comply with the requirements outlined in the 2011 SEBAC Agreement.

☐ I do NOT elect to participate at this time. I understand I will not be given another opportunity to enroll in the Health Enhancement Program until next year's annual Open Enrollment period.

CONSENT TO PARTICIPATE

My enrolled spouse and dependents and I agree to participate in the State of Connecticut Health Enhancement Program sponsored by my employer, the State of Connecticut. Information regarding my personal health and the health of my dependents will continue to be protected by all applicable state and federal laws and regulations. I and my enrolled dependents agree to comply with the requirements of the program including the applicable schedule of physical examinations, the applicable schedule of preventive screenings, and participation in any of the five disease counseling and education programs should I or any dependent be diagnosed with one or more of the five listed chronic diseases (Diabetes, Chronic Obtrusive Pulmonary Disorder or Asthma, Hypertension, Hyperlipidemia (high cholesterol), or Coronary Artery Disease (heart disease/heart failure). I understand my participation may be revoked should I not comply with my commitment to the Health Enhancement Program. I understand and agree that my revocation will make me responsible for higher premium co-shares of $100 per month, a $350 deductible per participant per year, and would make me 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 participation and the participation of my enrolled dependents, if any, in the Health Enhancement Program.

I accept the terms of the Health Enhancement Program as stated in the 2011 SEBAC Agreement.

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)	