Enrolling in the Health Enhancement Program (HEP)

- Go to the following website: www.CTHEP.com
- You will then be directed to the following webpage:

Enter the information requested above at the sections marked by the red arrows and click on the “Submit” button
- You will now be directed to the following webpage:
- Verify that the Full Name and Birthday that is listed for you at the left-hand side of the screen is correct. If this information is not correct please contact Fred Cratty in the Human Resources Department at 203-837-8665.
- Enter a home or cell phone number and e-mail address as requested.
- Double check the information you are submitting, check the verification box, and then click on the “Submit” button.
- You will now be directed to the following webpage:

![Health Enhancement Program Image]

- I will 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 the 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 Obstructive 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-pays of $100 per month, a $55 per participant per year deductible, and would make me ineligible for reductions in the copays for certain prescriptions and office visits. I recognize that I may be 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.

[Submit]

Check here to consent

- Once at the above page you need to click the radio dial button next to the option that you are selecting.
- After doing so check the box labeled “Check here to consent” and then click on the “Submit” button at the bottom of the screen.
- You will then be directed to the following webpage:
- Make sure to click on the “Click Here for a Printer Friendly Confirmation Statement” and print a copy for your records.
- At this point you have completed the necessary election designation and will not have to do so again until the next open enrollment period next year.