Employer: Complete Section A **Employee:** Complete Section B-H

Cigna Health and Life Insurance Company
Cigna Dental Health of Virginia, Inc.

Enrollment/Change Form

A						
☐OPEN ENROLL ☐ CHANGE ☐ NEW ENROLL ☐ REINSTATE	EFFECTIVE DATE OF CHANGE ADD/CHANGE/CANCELLATION (MM/DD/CCYY) _____/_____/_____	EMPLOYER NAME	DATE OF HIRE (MM/DD/CCYY) _____/_____/_____	PLAN NUMBER	SUBGROUP	CLASS

B	
☐ SINGLE ☐ MARRIED _____/_____/_____ ☐ SEPARATED ☐ DIVORCED ☐ WIDOWED	TYPE OF CHANGE ☐ Add Dependent(s) * ☐ Demographics ☐ PCP Change ☐ Retirement * List Name(s) in Section C ☐ COBRA Continuation Qualifying Event Date:__/__/__ ☐ Other______________

C		
EMPLOYEE NAME *(Last)*	*(First)*	SOCIAL SECURITY NUMBER - -
EMPLOYEE DATE OF BIRTH (MM/DD/CCYY) _______/_______/_______	HOME PHONE (_________)	EMAIL ADDRESS
ADDRESS *(Street)* *(City)*	*(State)*	*(Zip Code)*

☐ YES, I WOULD LIKE COVERAGE FOR MYSELF AND MY DEPENDENTS. (Specify last name if different from yours) Last Name First Name	DEPENDENT SOCIAL SECURITY NUMBER	DATE OF BIRTH (MM/DD/CCYY)	GEN-DER	COVERAGE SELECTION	Full-Time Student? Yes No	Please list PCP below (optional)	Dental Late Entrant? Yes No	If you choose the Cigna Dental Care Option: Enter your 1st and 2nd choice of Dental Office Number below.	Existing Patient? Yes No	Check One
Employee	- -	/ /	☐M ☐F	☐Medical ☐Dental ☐Vision	☐ ☐		☐ ☐	1st Choice - 2nd Choice -	☐ ☐	☐Add ☐Cancel
Dependent* Relationship	- -	/ /	☐M ☐F	☐Medical ☐Dental ☐Vision	☐ ☐		☐ ☐	1st Choice - 2nd Choice -	☐ ☐	☐Add ☐Cancel
Dependent* Relationship	- -	/ /	☐M ☐F	☐Medical ☐Dental ☐Vision	☐ ☐		☐ ☐	1st Choice - 2nd Choice -	☐ ☐	☐Add ☐Cancel
Dependent* Relationship	- -	/ /	☐M ☐F	☐Medical ☐Dental ☐Vision	☐ ☐		☐ ☐	1st Choice - 2nd Choice -	☐ ☐	☐Add ☐Cancel
Dependent* Relationship	- -	/ /	☐M ☐F	☐Medical ☐Dental ☐Vision	☐ ☐		☐ ☐	1st Choice - 2nd Choice -	☐ ☐	☐Add ☐Cancel

ADDITIONAL INFORMATION - * DEPENDENTS – If totally disabled prior to age 26, attach proof of disability for eligibility review. Dependents are covered under the medical plan to age 26. Proof of student status may be required for dental and/or vision coverage.

Cigna Medical and Cigna Vision Care plans listed in the below section are underwritten or administered by Cigna Health and Life Insurance Company (CHLIC). DHMO (Cigna Dental Care®) plans are underwritten by Cigna Dental Health of Virginia, Inc., an affiliate of CHLIC and a subsidiary of Cigna Dental Health, Inc. Cigna Dental PPO, EPO and Traditional plans are underwritten by CHLIC, with network management services provided by Cigna Dental Health, Inc.

D MEDICAL OPTIONS:

☐	Consumer Advantage® ____________________
☐	PPO____________________
☐	HRA____________________
☐	HSA (with Banking)____________________
☐	HSA (without Banking)____________________
☐	Open Access Plus____________________
☐	Indemnity____________________
☐	Cigna Care Network® ____________________
☐	Decline Coverage

E

DENTAL OPTIONS:		VISION OPTIONS:	
☐	Cigna Traditional ____________________	☐	Cigna Vision
☐	Cigna Dental PPO ____________________	☐	Decline Coverage
☐	Cigna Dental Care® DHMO ____________________		
☐	Cigna Dental EPO ____________________		
☐	Decline Coverage		

F FLEXIBLE SPENDING ACCOUNT OPTIONS:

☐	Healthcare **
☐	Dependent Care **
☐	Decline Coverage

** If you have elected one of the Flexible Spending Accounts in this section, please complete the corresponding enrollment form included in this package.

G OTHER HEALTHCARE COVERAGE: Do you or your dependents have other health insurance under a group plan, HMO, or Medicare? ☐ Yes ☐ No If yes, please provide the following:

NAME OF PERSON COVERED	SOCIAL SECURITY NUMBER	EFFECTIVE DATE	MEDICARE Part A	MEDICARE Part B	MEDICAID	OTHER INSURANCE CARRIER
	- -	_____/_____/_____	☐	☐	☐	
	- -	_____/_____/_____	☐	☐	☐	

H The information provided above is true and correct to the best of my knowledge, and I accept the provisions on the reverse side of this form which I have read and understand.

EMPLOYEE SIGNATURE / DATE

FRAUD WARNING

Any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated state law.

AUTHORIZATION TO DEDUCT CONTRIBUTIONS

I authorize deductions from my earnings of the required contributions, if any, toward the cost of the coverage. This authorization applies only if employee contributions are required.

SPECIAL PROVISIONS FOR EMPLOYERS WITH SECTION 125 PLANS

By allowing an individual to enroll in the health plan, other than during the open enrollment period, Cigna Health and Life Insurance Company and its affiliates do not waive any terms of its contract. Further, by allowing an individual to enroll in the health plan, other than during an open enrollment period, Cigna Health and Life Insurance Company and its affiliates do not thereby express any opinion regarding the appropriateness of the change under Section 125 of the Internal Revenue Code or the terms of the employer's Section 125 Plan.