Primary Applicant Name _____

Cigna Health and Life Insurance Company

Application for Dental, Vision and Hearing Insurance

Instructions:

- All answers must be complete and truthful.
- Print clearly using black or blue ink.
- The application must be received by us within 30 days from the signature date.

Important Information:

- Coverage will become effective only if this application enrollment form is complete, accepted and appropriate premium is provided.
- Your effective date will be assigned by us, based on the signature date of your application.
- Do not cancel your current coverage until you have received notification from Cigna Health and Life Insurance Company that your coverage is effective.
- Requested Effective Date cannot be greater than 60 days after the signature date. No Effective Dates will be assigned prior to or on the Signature date.
- If you have questions about completing this application, please contact your insurance agent or call Cigna Health and Life Insurance Company at 1.866.GET.Cigna (1.866.438.2446) 8 am - 8 pm ET, Monday – Friday.

Return the completed and signed application to your insurance agent or submit to:

Cigna Health and Life Insurance Company
Individual and Family Plans
P.O. Box 30362
Tampa, FL 33630-3362

FAX: 1.877.484.5927

Section A. Primary Applicant Information (Parent/Guardian for Child-Only application)

Primary Applicant Name (parent/guardian for child only) Last Name	First Name	Middle Initial

Relationship (if Child-Only Application)	**Marital Status** (Check one) ☐ Single ☐ Married

Applicant Residential/Home Address Street Address (Required; cannot be a P.O. Box)		Apt. Number
City	State	ZIP Code
Mailing Address for billing/premium notifications (if different from Residential/Home Address; can be a P.O. Box)		Apt. Number
City	State	ZIP Code

Email Address _____

I prefer to receive written correspondence regarding this application at the email address provided in this application.

(Check one) ☐ Yes ☐ No

Telephone Number

Primary _____ ☐ Home ☐ Work ☐ Cell

Secondary _____ ☐ Home ☐ Work ☐ Cell

By signing this application and providing my phone number or email, I agree that Cigna, its affiliates, and representatives may contact me regarding additional products or services by calling or texting me at the number above, by email, or by letter. I agree that Cigna may use the information provided or obtained in connection with this application, or insurance coverage provided by Cigna including my personal information, to offer me additional products and services or to send related marketing communications regarding Cigna products. I acknowledge that I am not required to provide consent to receive these communications as a condition of applying for coverage. If I choose not to receive marketing communications, I will indicate that below or can withdraw my consent at any time by contacting Cigna.

☐ I do not consent to receive marketing communications.

Primary Applicant Name _____

Section B. Dental, Vision and Hearing Coverage Request

1. Requested Effective Date: 1st of the Month of _____

Next available effective date will be assigned if not selected by the applicant.

2. Who Needs Coverage:

☐ Primary Applicant Only ☐ Primary Applicant and Dependent(s)

☐ Child(ren) Only - under age 18

Custodial Parent or Legal Guardian Name: _____

First / Middle Initial / Last

3. Application Type:

☐ New Dental, Vision and Hearing Coverage ☐ Add Family Member(s) to existing Dental, Vision and Hearing Coverage policy*

☐ Reinstatement* ☐ Request Plan Change*

*Policyholder's Name: _____ ID Number: _____

Section C. Benefit Plan Option Select the plan that best meets your needs.

☐ Cigna Dental Vision 1000 ☐ Cigna Dental Vision Hearing 2000 ☐ Cigna Dental Vision Hearing 3500

Note: These stand-alone dental plans do not meet the Affordable Care Act essential health benefit requirement for an Exchange-certified pediatric dental policy.

Section D. Applicant(s) Applying for Coverage Dependent children are eligible for coverage up to age 26.

Last Name	First Name	M.I.	Age	Date of Birth MM/DD/YYYY	Gender	Social Security Number/TIN
Primary Applicant					☐ Male ☐ Female ☐ X	
Custodial Parent or Legal Guardian Name (for Primary Applicants under age 18)					Relationship to Applicant:	
Spouse/Partner					☐ Male ☐ Female ☐ X	
Dependent 1					☐ Male ☐ Female ☐ X	
Dependent 2					☐ Male ☐ Female ☐ X	
Dependent 3					☐ Male ☐ Female ☐ X	
Dependent 4					☐ Male ☐ Female ☐ X	

☐ Check here if you are providing names of additional dependents on an attached separate page.

Section E. Prior / Current Dental Coverage Information

1. Do you (primary applicant) have prior or current coverage? ☐ Yes ☐ No

1a. If you have <u>current</u> dental coverage, is this plan intended to replace your coverage? ☐ Yes ☐ No

Note: If "Yes", you must read and date the Notice to Applicant Regarding Replacement of Insurance in Section F.

2. If you answered "Yes" to Question 1 above, please provide the following information:

Primary Applicant Name _____

Most recent coverage start date: (MM/DD/YYYY) _____ Termination date: (MM/DD/YYYY) _____

Name of prior or current plan carrier: _____ Policy Number: _____

Type of prior or current plan: ☐ Full coverage dental plan ☐ Preventive only dental plan ☐ Discount dental plan

☐ Other (please explain) _____

Section E. Prior / Current Dental Coverage Information *Continued from previous page.*

3. Does the coverage information provided in #2 above apply to all family members on this application? ☐ Yes ☐ No

If "No", please provide additional coverage information in the space provided below.

Spouse/Partner Name _____

Most recent coverage start date: (MM/DD/YYYY) _____ Termination date: (MM/DD/YYYY) _____

Name of prior or current plan carrier: _____ Policy Number: _____

Type of prior or current dental plan: ☐ Full coverage dental plan ☐ Preventive only dental plan ☐ Discount dental plan

☐ Other (please explain) _____

Dependent 1 Name _____

Most recent coverage start date: (MM/DD/YYYY) _____ Termination date: (MM/DD/YYYY) _____

Name of prior or current plan carrier: _____ Policy Number: _____

Type of prior or current dental plan: ☐ Full coverage dental plan ☐ Preventive only dental plan ☐ Discount dental plan

☐ Other (please explain) _____

Dependent 2 Name _____

Most recent coverage start date: (MM/DD/YYYY): _____ Termination date: (MM/DD/YYYY) _____

Name of prior or current plan carrier: _____ Policy Number: _____

Type of prior or current plan: ☐ Full coverage dental plan ☐ Preventive only dental plan ☐ Discount dental plan

☐ Other (please explain) _____

Dependent 3 Name _____

Most recent coverage start date: (MM/DD/YYYY): _____ Termination date: (MM/DD/YYYY) _____

Name of prior or current plan carrier: _____ Policy Number: _____

Type of prior or current dental plan: ☐ Full coverage dental plan ☐ Preventive only dental plan ☐ Discount dental plan

☐ Other (please explain) _____

Section F. Notice to Applicant regarding Replacement of Insurance

Complete this section only if you are replacing an existing insurance policy with a Cigna Health and Life Insurance Company policy

According to your application, you intend to lapse or otherwise terminate your existing insurance and replace it with a policy to be issued by Cigna Health and Life Insurance Company. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy.

1. You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.
2. Questions in the application for the new policy must be answered truthfully and completely; otherwise, the validity of the policy and the payment of any benefits thereunder may be voided.
3. The new policy may be issued at a higher age than that used for issuance of your present policy; therefore, the cost of the new policy, depending upon the benefits, may be higher than you are paying for your present policy.
4. The renewal provisions of the new policy should be reviewed so as to make sure of your rights to periodically renew the policy.
5. After the application has been completed and before you sign it, reread it carefully to be certain that all information has been properly recorded.

The above 'Notice to Applicant' was delivered to me on: _____

Today's Date: (MM/DD/YYYY)

Section G. Payment Options
Select the method of payment and enter account information for your initial and ongoing/subsequent payments.

Payment and Billing Method Definitions

- **Easy Pay - Electronic Funds Transfer (EFT):** The premium amount will be withdrawn from your bank account using the account information provided below.
- **Credit Card:** The premium amount will be charged to a credit card using the account information provided below.
- **eBill:** *Available for ongoing monthly payments only.* You will receive a monthly email notification at the email address provided on this application reminding you to pay your monthly premium on the online payment portal, where you will be able to select your payment method.
- **Paper Check:** Mail the paper application with a paper check for your initial payment. If selected for subsequent monthly payments, a paper billing notification will be mailed to your billing address (if different from your residential/home address).

1. Payment Methods

a. Select Initial Premium Payment Method (first month) Note: EFT (Automatic draft from a checking or savings account) and Credit Card are the only initial payment methods allowed for online or faxed applications. The initial payment will be collected from the account provided below upon processing the Application.

☐ Easy Pay - Electronic Funds Transfer (EFT) ☐ Credit Card Payment ☐ Paper Check (to be mailed with this application)

b. Select Ongoing Monthly Premium Payment Method *No paper or electronic monthly billing statement will be issued for automatic EFT and Credit Card payments.*

☐ Easy Pay - Electronic Funds Transfer (EFT) ☐ Automatic Credit Card Payment ☐ Paper Check (You will receive a paper bill.)

☐ eBill - Individual monthly payment (You will receive eBill notice at the email address provided on this application.)

2. Payment Account Information – Enter the bank account and/or credit card information for the payment options selected above.

a. Easy Pay - Electronic Funds Transfer (EFT): Automatic draft from a checking or savings account

Account Number: _____ ☐ Checking ☐ Savings

Routing Number: ☐☐☐☐☐☐☐☐☐

Name of Bank: _____ Name(s) on Account: _____

I authorize the Company (Cigna Health and Life Insurance Company) to make premium withdrawals, in the amount of the premium payment noted above, from my bank account as identified on this form and authorize the banking facility (Bank) to charge such withdrawals to my account. This authority will remain in effect until the Company receives written notice from me that the authority is terminated. Such termination will be effective with respect to the next premium due following 21 days after the written notice is received by the Company. I understand that if for any reason, a withdrawal is not honored by the Bank (including, but not limited to, insufficient funds or my direction to the Bank not to honor the withdrawal) my health care contract premium will be unpaid, and failure to pay my health care contract premium may result in termination for my health care contract, and that this authorization will remain in place until cancelled and that any due or past due premiums may be withdrawn under this authorization. I understand and agree that termination of this authorization does not relieve me of responsibility for charges incurred under my health care contract. I agree to indemnify and hold harmless the Company and its affiliates and employees for any claims arising out of transfers or deductions from my account in accordance with this authorization.

b. Credit Card ☐ VISA ☐ MASTERCARD

Card Number: ☐☐☐☐ – ☐☐☐☐ – ☐☐☐☐ – ☐☐☐☐

Name on Credit Card: _____ ZIP Code: _____

Expiration Date: _____ 3-digit Code: ☐☐☐

Section H. Statement of Accountability –
To be completed when the applicant cannot complete this application.

I, _____ personally read and completed this Application form for the Primary Applicant because:
First / Last Name

☐ Applicant does not read English ☐ Applicant does not speak English ☐ Applicant does not write English

☐ Other – explain: _____

_____ _____
Signature of Translator *required* (Excludes Parent Signature if Child-Only Application) Today's Date *required* (MM/DD/YYYY)

Primary Applicant Name _____

Section I. Conditions and Agreement/Authorization

1. I understand that any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime. Penalties may include denial of insurance benefits, fines, imprisonment, or any combination thereof.
2. I understand that I or my authorized representative is entitled to receive a copy of this authorization form.
3. I understand that I have the right to access and correct any personal information collected.
4. I understand that information disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and will no longer be protected by federal privacy regulations.
5. If the applicant is a minor, I accept full legal and financial responsibility for the coverage and information provided on this application. (Court documents establishing guardianship must be submitted if the responsible adult is not the parent).
6. I acknowledge and agree that coverage shall become effective only after (a) this signed Application has been accepted by Cigna Health and Life Insurance Company, and (b) a policy has been issued by Cigna Health and Life Insurance Company.

I AGREE ON BEHALF OF MYSELF AND AS AUTHORIZED AGENT OR REPRESENTATIVE OF MY ELIGIBLE DEPENDENTS TO THE PROVISIONS CONTAINED ON THIS FORM, INCLUDING THE PROVISIONS REGARDING THE COLLECTION, USE, AND DISCLOSURE OF PROTECTED HEALTH INFORMATION.

All applicants 18 years and older must sign and date application. Applicants under the age of 18 require custodial parent or legal guardian signature acknowledging their understanding of and agreement to the conditions listed above.

The above statements are true and complete to the best of my knowledge and belief. All statements in the application are representations and not warranties.

I understand and agree that for my child, and/or me and my eligible dependents, these statements shall be the basis for determination of acceptance for coverage under my applicable Cigna Health and Life Insurance Company benefit plan.

By signing the application I acknowledge that I have viewed or will view the Summary of Benefits and/or Outline of Coverage for the plan for which I am applying. These documents are available at www.Cigna.com.

I acknowledge and agree that any misrepresentation or intentional omission may render this contract null and void from its date of issue in accordance with applicable law. If my coverage is revoked, I will receive written notice that will explain the decision and my right to appeal. I also understand that I will be required to pay for any services that were covered while a member and that Cigna Health and Life Insurance Company will refund all amounts paid by me except amounts owed to Cigna Health and Life Insurance Company.

Primary Applicant Signature:	Today's Date: (MM/DD/YYYY)
Custodial Parent or Legal Guardian Signature (for applicants under the age of 18):	Today's Date: (MM/DD/YYYY)

Section J. Agent/Producer Information

Writing Agent/Producer Name:		Agent/Producer Code:	
Street Address:	City:	State:	ZIP Code:
Phone Number:	Email Address:		

Are you aware of any information about your client not disclosed on this application? ☐ Yes ☐ No

Did you see the proposed applicant at the time this application was completed? ☐ Yes ☐ No

If "No", please explain: _____

I verify that: 1) the application was completed by the applicant unless otherwise noted in the Statement of Accountability; 2) any information recorded by me on this application is true and accurate to the best of my knowledge and belief; and 3) applicant has received any required Summary of Benefits and/or Outline of Coverage.

Signature of Writing Agent/Producer: _____ _____
Date (MM/DD/YYYY)

Please enter the name of the Agency/Producer that checks are to be made payable to <u>if different from Writing Agent/Producer</u>:

Agent/Producer Last Name:	Agent/Producer First Name:	Agent/Producer Code:	
Street Address:	City:	State:	ZIP Code:
Phone Number:	Email Address:		