Cigna Medicare Supplement Insurance
Cigna National Health Insurance Company

APPLICATION BOOKLET FOR MARYLAND

This packet contains all required forms for application submission. Please complete each form according to the instructions on each page.

- Application
- Supplementary application
- Electronic funds transfer agreement(s)
- HIPAA notices
- Replacement notice(s)

Note: All Applications outside of OE/GI require a Phone Verification (PV) – Reduce delays and make the PV call at the point-of-sale. **Call our PV Hotline at 866.825.4822 from 7 a.m. to 7 p.m. Central Time.**

Together, all the way.®

Cigna.

APPLICATION for MEDICARE SUPPLEMENT INSURANCE

Cigna National Health Insurance Company
PO Box 5725, Scranton, PA 18505-5725 • 866-459-4272 • www.Cigna.com
Phone Verification (PV) Hotline 866-825-4822 • FaxApp Submission 877-704-8186

Application is for: ☐ New business ☐ Reinstatement Phone verification case #(s) _____

› If you complete this application with another Applicant, you are consenting to the other Applicant viewing the protected health information that you provided on this application.

› If only one Applicant, complete Applicant A questions.

A. Personal information

Applicant A

Name *(First MI Last)*	**Age**	**Date of birth** *(MM/DD/YYYY)*	**Gender** ☐ Male ☐ Female

Resident address *(Street, City, State ZIP)* | **Phone** ( )

Mailing address *(if different from resident address)* | **Social Security no.** *(XXX-XX-XXXX)*

Email address *(optional) By providing your email address, you agree to receive marketing content electronically and will receive a consent form authorizing electronic correspondence for policy delivery.*

Applicant B

Name *(First MI Last)*	**Age**	**Date of birth** *(MM/DD/YYYY)*	**Gender** ☐ Male ☐ Female

Resident address *(Street, City, State ZIP)* – OR check box ❑ if same as Applicant A | **Phone** ( )

Mailing address *(if different from resident address)* | **Social Security no.** *(XXX-XX-XXXX)*

Email address *(optional) By providing your email address, you agree to receive marketing content electronically and will receive a consent form authorizing electronic correspondence for policy delivery.*

Premium discount (see Outline of Coverage for details)

	Applicant A YES	Applicant A NO	Applicant B YES	Applicant B NO
1. a. Do you live with another adult who is age 18 years or older? If YES, you qualify for a 6% premium discount.	☐	☐	☐	☐
b. If YES to 1a, do they have a Medicare Supplement policy with Cigna National Health Insurance Company or an affiliate of Cigna National Health Insurance Company? If YES, you qualify for an additional 14% premium discount for a total of 20% premium discount.	☐	☐	☐	☐

2. If you answered YES to 1b, please provide member information if other than Applicant A or Applicant B.

Name *(First MI Last)* | **Social Security no.** *(XXX-XX-XXXX)*

B. Please provide your Medicare information *(as shown on your Medicare card)*

Applicant A

Medicare number _____

Hospital (Part A) coverage starts *(MM/DD/YYYY)* _____

Medical (Part B) coverage starts *(MM/DD/YYYY)* _____

Applicant B

Medicare number _____

Hospital (Part A) coverage starts *(MM/DD/YYYY)* _____

Medical (Part B) coverage starts *(MM/DD/YYYY)* _____

You must have both Medicare Parts A and B on your requested Medicare Supplement effective date for coverage to be issued.

C. Select a plan and effective date

Applicant A Check plan selected: ☐ Plan A ☐ Plan F* ☐ Plan G ☐ Plan N

Applicant B Check plan selected: ☐ Plan A ☐ Plan F* ☐ Plan G ☐ Plan N

Requested Medicare Supplement effective date *(MM/DD/YYYY)* **A** _____ **B** _____

(if no effective date is requested, we will assign the 1st day of the month following the date of this application)

*Plan F is only available if you are first Medicare-eligible before 2020.

D. Are you eligible for Open Enrollment or Guaranteed Issue?

If you lost or are losing other health insurance coverage and received a notice from your prior insurer saying you were eligible for Guaranteed Issue of a Medicare Supplement insurance policy or that you had certain rights to buy such a policy, you may be guaranteed acceptance in one or more of our Medicare Supplement plans. **Please include a copy of the notice from your prior insurer with your application.**

PLEASE ANSWER ALL QUESTIONS *(mark* YES *or* NO *below with an* "X"*)*.

To the best of your knowledge:

		Applicant A YES	Applicant A NO	Applicant B YES	Applicant B NO
1.	a. Did you turn age 65 in the last six (6) months?	☐	☐	☐	☐
	b. Did you enroll in Medicare Part B in the last six (6) months?	☐	☐	☐	☐
	If YES, what is the effective date? *(MM/DD/YYYY)* **A**_____ **B**_____				
2.	Are you covered for medical assistance through the state Medicaid program? (Note to Applicant: if you are participating in a "Spend-Down Program" and have not met your "Share of Cost", please answer NO to this question.)	☐	☐	☐	☐
	If YES,				
	a. will Medicaid pay your premiums for this Medicare Supplement policy?	☐	☐	☐	☐
	b. do you receive any benefits from Medicaid other than payments toward your Medicare Part B premium?	☐	☐	☐	☐
3.	Are you covered under the Medicaid program for more than six (6) months from the effective date of your enrollment in Medicare Part B, due to the continuous enrollment provision for COVID-19?	☐	☐	☐	☐
	If YES, eligible individuals who missed their Medicare supplement open enrollment period as a result of the Medicaid continuous coverage provision will have a 63-day period to enroll in a Medicare supplement policy without underwriting. See Section F. Important statements for the Applicant to read, which addresses the circumstances in which an individual is eligible for a new special enrollment period.				
4.	Have you had coverage from any Medicare plan other than original Medicare within the past 63 days (for example, a Medicare Advantage plan or a Medicare HMO or PPO)?	☐	☐	☐	☐
	If YES,				
	a. fill in your START and END dates below *(if you are still covered under this plan, leave the END date blank)*.				
	A START _____ END _____				
	B START _____ END _____				
	b. if you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare Supplement policy?	☐	☐	☐	☐
	c. was this your first time in this type of Medicare plan?	☐	☐	☐	☐
	d. did you drop a Medicare Supplement policy to enroll in the Medicare plan?	☐	☐	☐	☐
5.	a. Do you have another Medicare Supplement policy in force?	☐	☐	☐	☐
	b. If so, with what company and which type plan option do you have?				
	A _____				
	B _____				
	c. If so, do you intend to replace your current Medicare Supplement policy with this policy?	☐	☐	☐	☐
	If existing Medicare Supplement coverage is not to be replaced, this policy cannot be issued.				
6.	a. Is any applicant under age 65 years, but eligible for Medicare due to a disability?	☐	☐	☐	☐
	b. Has any applicant been notified by Medicare of their retroactive enrollment in Medicare, during the six (6) month period following notification of enrollment by Medicare?	☐	☐	☐	☐
	If YES to a and b, the applicant is eligible for Medicare supplement policy plans A or D.				

7. Have you had coverage under any other health insurance within the past 63 days (for example, an employer, union, or individual plan)? ☐ ☐ ☐ ☐

a. If so, with what company and what kind of policy?

A _____

B _____

b. What are your dates of coverage under the other policy? *(If you are still covered under the other policy, leave the END date blank.)*

A START _____ END _____

B START _____ END _____

E. Complete medical questions

IF YOU ARE ELIGIBLE FOR OPEN ENROLLMENT OR GUARANTEED ISSUE (BASED ON YOUR ANSWERS IN SECTION(S) B & D), DO NOT ANSWER THE QUESTIONS IN THIS SECTION.

If you are applying for coverage prior to or during the 6-month period beginning with the first day of the first month in which you are enrolled for the benefits under Medicare Part B, then you are eligible for open enrollment and do not need to answer the questions in Section E.

If you are currently covered under a Medicare supplement policy and you are applying within thirty (30) days of your birthday, we will make available to you a different Medicare supplement policy plan with benefits that are equal to or less than the benefits of your existing coverage. Please see the "Birthday Rule" information in this application, which is located under Section F. Important Statements for Applicant to Read.

It is important that you provide truthful and accurate answers to the questions in this section as your answers form the basis of our determination of your eligibility for this coverage. Failure to provide complete and accurate information, if it is determined to be material to our assessment, may result in future denial of benefits and/or rescission of this coverage.

PART A. MEDICAL QUESTIONS – If the answer to any question in Part A is YES, you are not eligible for coverage.

	APPLICANT A		APPLICANT B	
	YES	NO	YES	NO
1. Are you confined, scheduled for admission, or in the last two (2) years have you been confined to a nursing facility or assisted living facility?	☐	☐	☐	☐
2. Do you receive home health care services; or in the last two (2) years, have you received home health care services for more than three (3) separate periods of care?	☐	☐	☐	☐
3. Are you currently diagnosed by a medical professional as having a terminal illness; are you in the hospital, pending hospital admission, or have you been hospitalized more than two (2) times in the last two (2) years?	☐	☐	☐	☐
4. Do you receive assistance bathing, transferring, toileting, eating, dressing, or are you bedridden; or, in the last seven (7) years, have you been advised by a medical professional to use the assistance of a wheelchair, walker, or motorized mobility aid?	☐	☐	☐	☐
5. Within the past six (6) months, have you been treated for or advised by a medical professional to have treatment for diabetes with hypertension that required three (3) or more hypertension medications to control or diabetes requiring more than 50 units of insulin daily to control?	☐	☐	☐	☐
6. Within the past two (2) years, have you been treated for (including surgery) or advised by a medical professional to have treatment or surgery for any of the following:	☐	☐	☐	☐
• heart attack, congestive heart failure, coronary bypass, or stroke? (You should answer NO if your only treatment has been less than three concurrent cardio-vascular medications and your treatment has not altered in the last two (2) years (e.g., change in medications or dosage increases)).				

7. In the last seven (7) years, have you been treated for (including surgery) or advised by a medical professional to have treatment or surgery for any of the following: ☐ ☐ ☐ ☐
   - muscular dystrophy, multiple sclerosis, or amyotrophic lateral sclerosis (Lou Gehrig's disease)?
   - Paget's disease, rheumatoid arthritis, disabling arthritis, osteoporosis with fractures, or paralysis?
   - chronic kidney disease, Addison's disease, renal insufficiency, renal failure, any kidney disease requiring dialysis, cirrhosis of the liver or any condition requiring an organ transplant?
   - bipolar disorder, schizophrenia, a paranoid disorder, severe depression, or treatment for depression with medication within a twelve (12) month period immediately preceding the effective date of coverage?
   - Alzheimer's disease?
   - organic brain disorder?
   - unrepaired aneurysm, hemophilia, or any other blood disorder?
   - any heart disease requiring a permanent, implantable cardiac defibrillator?
8. Within the past two (2) years, have you been treated for (including surgery) or advised by a medical professional to have treatment or surgery for any of the following: ☐ ☐ ☐ ☐
   - any cancer, excluding skin cancer (except malignant melanoma)?
   - anemia requiring repeated blood transfusions?
   - alcohol or drug abuse (including counseling)?
   - pancreatitis?
   - seizure?
9. In the past seven (7) years, have you been treated for or advised by a medical professional to have treatment for an amputation caused by disease or for an organ transplant (other than corneas)? ☐ ☐ ☐ ☐
10. In the last seven (7) years, have medical tests, treatment, therapy, or surgery been advised but not performed or is any surgery anticipated? (This excludes mammograms, pap tests, colonoscopies, or PSA tests which were advised for routine screening purposes only.) ☐ ☐ ☐ ☐
11. Do you have now or, within the last seven (7) years, have you been diagnosed with or received medical advice or treatment from a physician or an appropriately-licensed clinical professional acting within his/her scope for Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or Human Immunodeficiency Virus (HIV) infection? ☐ ☐ ☐ ☐

If you answered NO to all questions in this Section, please continue to Part B. >>>

PART B. MEDICAL QUESTIONS AND MEDICATIONS – The answers to questions in Part B are subject to the Company's underwriting review and may result in a decline. Please provide complete details as requested.

12. **Applicant A** Height *(ft.-in.)* _____ Weight *(lbs.)* _____
    Applicant B Height *(ft.-in.)* _____ Weight *(lbs.)* _____

	APPLICANT A		APPLICANT B	
	YES	NO	YES	NO
13. a. Have you used tobacco within the last 12 months?	☐	☐	☐	☐
b. If YES, do you currently have a heart condition, vascular condition, or diabetes?	☐	☐	☐	☐
14. In the last two (2) years, have you been treated for or advised by a medical professional to have treatment for any of the following:	☐	☐	☐	☐
• angioplasty, atherosclerosis or arteriosclerosis, peripheral vascular disease, carotid artery disease, coronary artery disease (CAD), angina, cardiomyopathy, stent placement, heart valve surgery, atrial fibrillation, irregular heartbeat, cardiac pacemaker, transient ischemic attack (TIA)? (You should answer NO if your only treatment has been less than three concurrent cardio-vascular medications and your treatment has not altered in the last two (2) years (e.g., change in medications or dosage increases).)				
15. In the last seven (7) years, have you been treated for or advised by a medical professional to have treatment for any of the following:				
• chronic obstructive pulmonary disease (COPD), chronic obstructive lung disease (COLD), emphysema, chronic bronchitis, or other chronic lung or respiratory disorder not listed that requires the permanent use of oxygen?	☐	☐	☐	☐
• diabetes with neuropathy, diabetes with retinopathy, or diabetes with vascular disease?	☐	☐	☐	☐
• cerebral palsy, myasthenia gravis, systemic lupus, or Parkinson's disease?	☐	☐	☐	☐
• hepatitis other than hepatitis A or other liver disease?	☐	☐	☐	☐
• dementia or senility?	☐	☐	☐	☐
• PSA levels greater than 6.0?	☐	☐	☐	☐

16. Please list any prescription medications taken or prescribed in the past two (2) years *(attach a separate sheet if needed)*.

Medication name	Dates taken	Reason for medication
Applicant A		
Applicant B		

F. Important statements for Applicant to read

- You do not need more than one Medicare Supplement policy.
- If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverages.
- You may be eligible for benefits under Medicaid and may not need a Medicare Supplement policy.
- Open Enrollment Period. If an application for a Medicare supplement policy or certificate is submitted during the six (6) month period beginning with the first month in which an individual who is at least 65 years old first enrolls for benefits under Medicare Part B, the company:
  1. may not deny or condition the issuance or effectiveness of the Medicare supplement policy or certificate or discriminate in the pricing of the Medicare supplement policy or certificate because of the health status, claims experience, receipt of healthcare, or medical condition of the applicant; or
  2. may not deny, reduce, or condition coverage or apply an increased premium rating to an applicant for a Medicare supplement policy because of the health status, claims experience, or medical condition of the applicant or use of medical care by the applicant.
- New Guarantee Issue Requirements for Certain Individuals.
  Carriers are required to issue any Medicare supplement policy available for sale in Maryland to an individual eligible for Medicare if the individual meets certain guaranteed issue requirements, which are provided in the application:
  1. Individual is enrolled in Medicare Part B while enrolled in the Maryland Medical Assistance Program;
  2. Individual remained in the Maryland Medical Assistance Program due to a suspension of terminations by the Maryland Medical Assistance Program during a state of emergency and you were note disenrolled or terminated until at least 6 months following the effective date of enrollment in Medicare Part B; and
  3. Individual applied for a Medicare supplement policy during the 63-day period following the later of the date of termination from the Maryland Medical Assistance Program or the date you are notified of termination from the Maryland Medical Assistance Program.

- If, after purchasing this policy, you become eligible for Medicaid, the benefits and premiums under your Medicare Supplement policy can be suspended, if requested, during your entitlement to benefits under Medicaid for 24 months. You must request this suspension within 90 days of becoming eligible for Medicaid. If you are no longer entitled to Medicaid, your suspended Medicare Supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstituted if requested within 90 days of losing Medicaid eligibility. If the Medicare Supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstituted policy will not have outpatient prescription drug coverage but will otherwise be substantially equivalent to your coverage before the date of the suspension.
- If you are eligible for and have enrolled in a Medicare Supplement policy by reason of disability and you later become covered by an employer or union-based group health plan, the benefits and premiums under your Medicare Supplement policy can be suspended, if requested, while you are covered under the employer or union-based group health plan. If you suspend your Medicare Supplement policy under these circumstances and later lose your employer or union-based group health plan, your suspended Medicare Supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstituted if requested within 90 days of losing your employer or union-based group health plan. If the Medicare Supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstituted policy will not have outpatient prescription drug coverage but will otherwise be substantially equivalent to your coverage before the date of the suspension.
- Counseling services may be available in your state to provide advice concerning your purchase of Medicare Supplement insurance and concerning medical assistance through the state Medicaid program, including benefits as a Qualified Medicare Beneficiary (QMB) and a Specified Low-income Medicare Beneficiary (SLMB).
- Medicare supplement "Birthday Rule." During the thirty (30) days following the Birthday of an individual enrolled in a Medicare supplement policy plan, we will make available to you a different Medicare supplement policy plan with benefits that are equal to or less than the benefits of your existing coverage. A Medicare supplement plan has equal or lesser benefits unless;
  1. it contains one or more significant benefits not included in the Medicare supplement policy being replaced; or
  2. it contains the same significant benefits included in the Medicare supplement policy being replaced but it reduces the cost-sharing responsibilities of the enrollee for the benefits.

For additional information you can refer to the outline of coverage or you can call 866-459-4272.

I hereby apply to Cigna National Health Insurance Company for coverage to be issued based upon questions that are answered truthfully and to the best of my knowledge and belief, and understand and agree that: (1) no agent has the authority to waive the answer to any questions on the application; (2) no insurance will be effective until (a) a policy has been issued by the Company and (b) the initial premium has been paid; and (3) I have received the Outline of Medicare Supplement Coverage for the policy applied for and the required *Guide to Health Insurance for People with Medicare*.

CAUTION: Please review your answers to the questions on the application. It is important to the issuance of this policy that all questions are answered correctly and truthfully.

WARNING: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or knowingly or willfully presents false information in an application for insurance may be guilty of a crime and may be subject to fines and confinement in prison.

A recorded telephone interview may be used as part of the underwriting on your application for insurance.

Applicant A Telephone number (_____) _____ Best time to call _____

Applicant B Telephone number (_____) _____ Best time to call _____

I understand that the Medicare Supplement policy applied for will not cover loss due to Pre-Existing Condition(s) unless the expense for that loss is incurred more than six (6) months after the effective date of coverage. This provision does not apply if, as of the date of application, you had a Continuous Period of Creditable Coverage which did not expire more than 63 days ago and such coverage, while in force, lasted for at least six (6) months. If, as of the date of application, you had less than six (6) months prior Creditable Coverage, the Pre-Existing Conditions limitation will be reduced by the aggregate amount of Creditable Coverage. If this policy is replacing another Medicare Supplement policy, credit will be given for any portion of the waiting period that has been satisfied. This provision does not apply if you are applying for and are issued this policy under Guaranteed Issue status.

Applicant A Signature _____ Date _____

Applicant B Signature _____ Date _____

G. Determine your rate class

A	B		
☐	☐	**Preferred**	If you're eligible for Open Enrollment/Guaranteed Issue or answered NO to section E, questions 13a, 14, and 15.
☐	☐	**Standard**	If you answered YES to section E, question 13a (tobacco use), and NO to questions 13b, 14, and 15.
☐	☐	**Standard II**	If you answered NO to section E, question 13a (tobacco use), and YES to question 13b, 14, or 15.
☐	☐	**Standard III**	If you answered YES to section E, question 13a (tobacco use), and YES to question 13b, 14, or 15.

Your eligibility for coverage and final rate class is subject to underwriting review. Medications and height and weight impact your rate class. Please refer to the declinable drug list and height and weight chart for guidance.

H. Choose your method of payment

Applicant A
Method *(select one of the following)*:

☐ Bank draft *(complete the Electronic Funds Transfer Agreement)*
☐ Direct bill *(enclose check payable to* **Cigna National Health Insurance Company***; do not send cash)*
☐ List bill Group name _____ Group number _____

Mode: ☐ Monthly *(bank draft or list bill only)* ☐ Quarterly ☐ Semi-annually ☐ Annually

Premium *(see rate chart in Outline of Coverage)* $_____
If you answered YES to Section A, question 1a, and NO to 1b, multiply premium by 0.94.
If you answered YES to Section A, questions 1a and 1b, multiply premium by 0.85.

Applicant B
Method *(select one of the following)*:

☐ Bank draft *(complete the Electronic Funds Transfer Agreement)*
☐ Direct bill *(enclose check payable to* **Cigna National Health Insurance Company***; do not send cash)*
☐ List bill Group name _____ Group number _____

Mode: ☐ Monthly *(bank draft or list bill only)* ☐ Quarterly ☐ Semi-annually ☐ Annually

Premium *(see rate chart in Outline of Coverage)* $_____
If you answered YES to Section A, question 1a, and NO to 1b, multiply premium by 0.94.
If you answered YES to Section A, questions 1a and 1b, multiply premium by 0.85.

I. Agent use only

Please answer all questions:

1. I certify that I have provided the Applicant(s) with the following documents:
   a. Application packet *(phone sales only)* b. *Guide to Health Insurance for People with Medicare*
   c. Outline of Medicare Supplement Coverage d. Other _____
   I further certify that I have delivered the documents to the Applicant(s) *(check all that apply; must select at least one)*:
   Date _____ ☐ In person ☐ Mail ☐ Email ☐ Fax ☐ Other *(explain)* _____
2. Do you have knowledge or reason to believe the replacement of existing insurance may be involved?
   Applicant A: ☐ YES ☐ NO **Applicant B**: ☐ YES ☐ NO
   If YES, give name of company, reason, and termination date:
   A _____
   B _____
3. List all other health insurance policies you have sold to the Applicant(s):
   Applicant A _____
   Applicant B _____

NOTES: Please provide additional information that may assist in processing this application (*attach a separate sheet if needed*).

_____

I certify that I have interviewed the Applicant(s), asked all of the questions as written on the application, and I have truly and accurately recorded on the application the information supplied to me by the Applicant(s).

Printed name of licensed Agent	Signature of licensed Agent	Writing number	Percentage
Printed name of 2nd licensed Agent	Signature of 2nd licensed Agent	Writing number	Percentage

CIGNA NATIONAL HEALTH INSURANCE COMPANY
PO Box 5725, Scranton, PA 18505-5725 • 866-459-4272

MEDICARE SUPPLEMENTARY APPLICATION

Definitions of Open Enrollment and Eligible Persons for Guaranteed Issue

Open Enrollment: The individual is applying for coverage prior to or during the six-month period beginning with the first day of the first month in which the individual enrolled for benefits under Medicare Part B, then he/she is eligible for open enrollment. If not, but the individual has lost or is losing other coverage, then he/she may be eligible for guaranteed issue.

A carrier shall make available Medicare Supplement policy plans A or D to an individual who is under the age of 65 years but is eligible for Medicare due to a disability if an application for a Medicare Supplement policy or certificate is submitted:

1) during the six-month period following the Applicant's enrollment in Part B of Medicare; or
2) if the Applicant is notified by Medicare of the Applicant's retroactive enrollment in Medicare during the six-month period following notification of enrollment in Medicare.

The following information can help the individual determine if the individual is eligible for Guaranteed Issue.

Eligible Persons for Guaranteed Issue An eligible person is an individual described in any of the following paragraphs:

1) The individual is enrolled under an employee welfare benefit plan that provides health benefits that supplement the benefits under Medicare and the plan terminates or the plan ceases to provide all supplemental health benefits to the individual;
2) The individual is enrolled with a Medicare Advantage organization under a Medicare Advantage plan under Part C of Medicare and any of the following circumstances apply:
   a) The certification of the organization or plan under the federal Social Security Act has been terminated;
   b) The organization has terminated or otherwise discontinued providing the plan in the area in which the individual resides;
   c) The individual is no longer eligible to elect the plan because:
      i) of a change in the individual's place of residence,
      ii) of another change in circumstances specified by the Secretary, but not including termination of the individual's enrollment on the basis described in section 1851(g)(3)(B) of the federal Social Security Act (when the individual has not paid premiums on a timely basis or has engaged in disruptive behavior as specified in standards under section 1856 of the federal Social Security Act), or
      iii) the plan is terminated for all individuals within a residence area;
   d) The individual demonstrates, in accordance with guidelines established by the Secretary, that:
      i) The organization offering the plan substantially violated a material provision of the organization's contract under Part C of Medicare in relation to the individual, including the failure to provide an enrollee on a timely basis medically-necessary care for which benefits are available under the plan or the failure to provide medically-necessary covered care in accordance with applicable quality standards, or
      ii) The organization or agent or other entity acting on the organization's behalf materially misrepresented the plan's provisions in marketing the plan to the individual; or
   e) The individual meets any other exceptional conditions as the Secretary may provide;
3) The individual is 65 years old or older and is enrolled with a Program of All-Inclusive Care for the Elderly (PACE) provider under section 1894 of the Social Security Act and there are circumstances similar to those described in (2) that would permit discontinuance of the individual's enrollment with the PACE provider if the individual were enrolled in a Medicare Advantage plan;
4) The individual
   a) is enrolled with:
      i) an eligible organization under a contract under section 1876 of the federal Social Security Act (Medicare cost),
      ii) a similar organization to the organization described in (i) operating under demonstration project authority, effective for periods before April 1, 1999,

iii) an organization under an agreement under section 1833(a)(1)(A) of the federal Social Security Act (health care pre-payment plan), or
iv) an organization under a Medicare Select policy; and

b) ceases to be enrolled under the same circumstances that would permit discontinuance of an individual's election of coverage under (2);

5) The individual is enrolled under a Medicare supplement policy and the enrollment ceases because of:
   a) The insolvency of the issuer or bankruptcy of the non-issuer organization or other involuntary termination of coverage or enrollment under the policy;
   b) The issuer of the policy substantially violated a material provision of the policy; or
   c) The issuer or an agent or other entity acting on the issuer's behalf materially misrepresented the policy's provisions in marketing the policy to the individual;

6) The individual:
   a) was enrolled under a Medicare supplement policy and terminates enrollment and subsequently enrolls for the first time with
      i) any Medicare Advantage organization under a Medicare Advantage plan under Part C of Medicare,
      ii) any eligible organization under a contract under section 1876 of the federal Social Security Act (Medicare cost),
      iii) any similar organization operating under demonstration project authority,
      iv) a Medicare Select policy, or
      v) any Program of All-Inclusive Care for the Elderly (PACE) provider under section 1894 of the Social Security Act; and
   b) terminates the subsequent enrollment under (6) during any period within the first 12 months of the subsequent enrollment (during which the enrollee is permitted to terminate the subsequent enrollment under section 1851(e) of the federal Social Security Act);

7) The individual, upon first becoming enrolled in Part B of Medicare at 65 years old or older, enrolls in a Medicare Advantage plan under Part C of Medicare or with a PACE provider under section 1894 of the Social Security Act and disenrolls from the plan or program by not later than 12 months after the effective date of enrollment; or

8) The individual:
   a) enrolls in a Medicare Part D plan during the initial enrollment period;
   b) at the time of enrollment in Part D
      i) was enrolled under a Medicare supplement policy that covers outpatient prescription drugs; and
      ii) terminates enrollment in the Medicare supplement policy described in (8)(b)(i); and
   c) submits evidence of enrollment in Medicare Part D with the application for a policy described in section E(5).

I acknowledge receipt of this Supplementary Application.

_____ _____

Signature of Applicant **Date**

PRE-AUTHORIZATION AGREEMENT FOR ELECTRONIC FUNDS TRANSFER

CIGNA NATIONAL HEALTH INSURANCE COMPANY • PO BOX 5725, SCRANTON, PA 18505-5725

☐ **Joint Account** – ***only one form is needed for Joint Account*** ☐ **Applicant A only** ☐ **Applicant B only**		
Proposed Insured Name		**Policy Number** *(if available)*
Financial Institution Name and Telephone Number		
9-digit Routing Number	**Account Number**	**Requested Withdrawal Date** *(1st - 28th)*

Withdraw Payment: ☐ Monthly ☐ Quarterly ☐ Semi-annually ☐ Annually

Type of Account: ☐ Personal Checking Account ☐ Personal Savings Account ☐ Corporate/Business Checking

Name of Employer Group _____

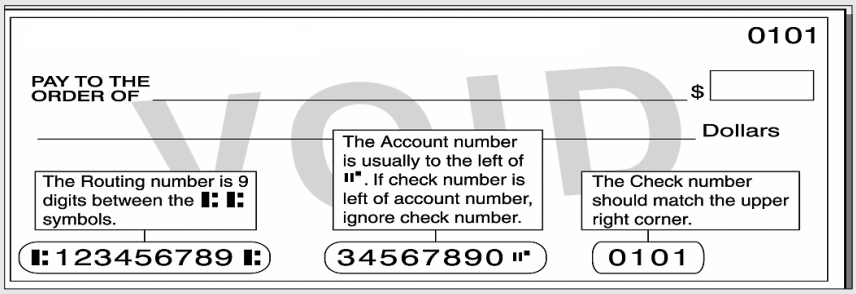
Purpose for submitting this Authorization (check appropriate box(es)):

☐ New authorization ☐ Change in checking/savings account

☐ Change in financial institution ☐ Change in existing coverage

For checking account:
Refer to the sections on the sample check.

For savings account:
Please verify with your bank the account and routing number of your savings account.



APPLICANT A OR APPLICANT B INFORMATION FOR FINANCIAL INSTITUTIONS: As a convenience to me, I hereby request and authorize you to pay and charge to my account, drafts drawn on my account by and payable to Cigna National Health Insurance Company provided there are sufficient funds in said account to pay the same on presentation. Such drafts will bear my printed name. I also authorize Cigna National Health Insurance Company and any financial institution it uses to initiate credit entries to my account or to provide refund of premium or association fees (if applicable). I authorize you to accept and to credit these entries to my account. In the event Cigna National Health Insurance Company mistakenly deposits funds into my account, I authorize Cigna National Health Insurance to debit my account for an amount not to exceed the original amount of credit. This authorization shall remain in effect until revoked by me in writing, and until you actually receive such notice. I agree that you shall be fully protected in honoring any such draft. I agree that your rights in respect to any such draft shall be the same as if it were a check signed personally by me. I further agree that if any such draft is dishonored, whether intentionally or inadvertently, you shall be under no liability whatsoever even though such dishonor results in the forfeiture of insurance.

APPLICANT A OR APPLICANT B INFORMATION FOR CIGNA NATIONAL HEALTH INSURANCE COMPANY: It is understood that the initial draft will occur when the policy is issued. All subsequent drafts will be drawn on or about the requested date each month. The presentation of such drafts to the above Financial Institution shall constitute notice of premiums being due upon the contract and association fees (if applicable), and no other notice of premiums or association fees (if applicable) due will be given. No premium or association fee (if applicable) shall be deemed to have been paid unless and until actual payment of the draft drawn for such premium or association fee (if applicable) payment has been received by Cigna National Health Insurance Company. The cancelled draft will constitute receipt of premium or association fee (if applicable) payment. The privilege of paying premiums and association fees (if applicable) under this Plan may be revoked by Cigna National Health Insurance Company if any draft is not paid upon presentation. The payment of premiums and association fees (if applicable) under this Plan may be terminated by the Contract Owner, Financial Institution Depositor if other than Contract Owner, or by Cigna National Health Insurance Company upon 30 days written notice.

Name of Payor *(if other than Insured)* **Payor's Address**

Print name of Depositor *(as it appears on account)* **Signature of Depositor** **Date**

PRE-AUTHORIZATION AGREEMENT FOR ELECTRONIC FUNDS TRANSFER

CIGNA NATIONAL HEALTH INSURANCE COMPANY • PO BOX 5725, SCRANTON, PA 18505-5725

☐ **Joint Account** – ***only one form is needed for Joint Account*** ☐ **Applicant A only** ☐ **Applicant B only**		
Proposed Insured Name		**Policy Number** *(if available)*
Financial Institution Name and Telephone Number		
9-digit Routing Number	**Account Number**	**Requested Withdrawal Date** *(1st - 28th)*

Withdraw Payment: ☐ Monthly ☐ Quarterly ☐ Semi-annually ☐ Annually

Type of Account: ☐ Personal Checking Account ☐ Personal Savings Account ☐ Corporate/Business Checking

Name of Employer Group _____

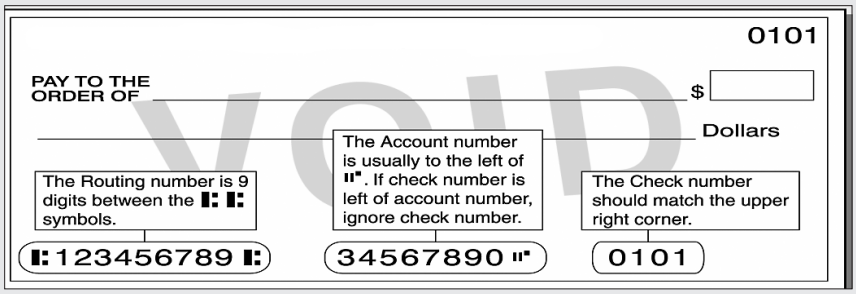
Purpose for submitting this Authorization (check appropriate box(es)):

☐ New authorization ☐ Change in checking/savings account

☐ Change in financial institution ☐ Change in existing coverage

For checking account:
Refer to the sections on the sample check.

For savings account:
Please verify with your bank the account and routing number of your savings account.



APPLICANT A OR APPLICANT B INFORMATION FOR FINANCIAL INSTITUTIONS: As a convenience to me, I hereby request and authorize you to pay and charge to my account, drafts drawn on my account by and payable to Cigna National Health Insurance Company provided there are sufficient funds in said account to pay the same on presentation. Such drafts will bear my printed name. I also authorize Cigna National Health Insurance Company and any financial institution it uses to initiate credit entries to my account or to provide refund of premium or association fees (if applicable). I authorize you to accept and to credit these entries to my account. In the event Cigna National Health Insurance Company mistakenly deposits funds into my account, I authorize Cigna National Health Insurance to debit my account for an amount not to exceed the original amount of credit. This authorization shall remain in effect until revoked by me in writing, and until you actually receive such notice. I agree that you shall be fully protected in honoring any such draft. I agree that your rights in respect to any such draft shall be the same as if it were a check signed personally by me. I further agree that if any such draft is dishonored, whether intentionally or inadvertently, you shall be under no liability whatsoever even though such dishonor results in the forfeiture of insurance.

APPLICANT A OR APPLICANT B INFORMATION FOR CIGNA NATIONAL HEALTH INSURANCE COMPANY: It is understood that the initial draft will occur when the policy is issued. All subsequent drafts will be drawn on or about the requested date each month. The presentation of such drafts to the above Financial Institution shall constitute notice of premiums being due upon the contract and association fees (if applicable), and no other notice of premiums or association fees (if applicable) due will be given. No premium or association fee (if applicable) shall be deemed to have been paid unless and until actual payment of the draft drawn for such premium or association fee (if applicable) payment has been received by Cigna National Health Insurance Company. The cancelled draft will constitute receipt of premium or association fee (if applicable) payment. The privilege of paying premiums and association fees (if applicable) under this Plan may be revoked by Cigna National Health Insurance Company if any draft is not paid upon presentation. The payment of premiums and association fees (if applicable) under this Plan may be terminated by the Contract Owner, Financial Institution Depositor if other than Contract Owner, or by Cigna National Health Insurance Company upon 30 days written notice.

Name of Payor *(if other than Insured)* **Payor's Address**

Print name of Depositor *(as it appears on account)* **Signature of Depositor** **Date**

AUTHORIZATION FORM FOR DISCLOSURE OF AN APPLICANT'S PROTECTED HEALTH INFORMATION

I hereby authorize the disclosure of protected health information about me as described below.

1. The Company, as used in this authorization, shall mean American Retirement Life Insurance Company, Loyal American Life Insurance Company®, Cigna Health and Life Insurance Company, Cigna National Health Insurance Company, and their affiliates as described below.
2. I authorize any licensed physician, medical practitioner, hospital, clinic, Pharmacy Benefit Manager, or other medical or medically-related facility, the U. S. Veterans Administration and Selective Service System, insurance company, MIB Group, LLC, or any other organization, institution, or person that has any records or information available as to the diagnosis, treatment, and prognosis with respect to any physical or mental condition and/or treatment relating to me or my family to disclose to the Company's underwriting, new business, claims, sales agents, and premium accounting representatives any such records or information. However, MIB Group, LLC, information will only be shared with the Company's underwriting staff and Medical Director.
3. I authorize the Company to make a brief report of my protected health information to MIB Group, LLC.
4. The protected health information described above will be disclosed to the Company to determine my or my family's eligibility to obtain coverage under the policy for which I/we have applied, and to determine the rates and terms which apply to the policy.
5. This medical or health information includes information on the diagnosis and treatment of mental illness, alcohol, and drug use. This also includes information on the diagnosis, treatment, and testing results related to HIV, AIDS, and sexually-transmitted diseases unless otherwise restricted by state law.
6. I understand that I may revoke this authorization in writing at any time, except to the extent that action has been taken by the Company in reliance on this authorization, by sending a written revocation to the Company's Privacy Office at PO Box 5700, Scranton, PA 18505-5700.
7. I understand that the information which will be provided under this authorization is necessary for the Company to determine my eligibility for coverage under the policy and that the Company will condition its approval and issuance of the policy on my providing this authorization, and my application may be denied if I refuse to provide this authorization.
8. I understand that if the person or entity that receives my protected health information is not a health care provider or health plan covered by the federal privacy regulations, the information may be re-disclosed by such person or entity and will likely no longer be protected by the federal privacy regulations.
9. I understand that a photocopy, facsimile copy, or other electronic copy of this authorization shall be considered as effective and valid as the original. I also understand that I or my personal representative am entitled to receive a copy of this authorization upon request. This authorization will expire twenty-four (24) months from the date it is signed.
10. If you are the representative of an Applicant, describe the scope of your authority to act on the Applicant's behalf:

_____

Applicant A Name

Name of Applicant A Personal Representative, if applicable

Applicant A Social Security Number

Relationship of Personal Representative to Applicant A

Applicant A Signature **Date**

Signature of Personal Representative **Date**

Applicant B Name

Name of Applicant B Personal Representative, if applicable

Applicant B Social Security Number

Relationship of Personal Representative to Applicant B

Applicant B Signature **Date**

Signature of Personal Representative **Date**

Signature of Company's Agent **Date**

A signed copy of this form will be provided with the policy if issued and any other time upon request.

AUTHORIZATION FORM FOR DISCLOSURE OF A CONSUMER'S PROTECTED HEALTH INFORMATION FOR MARKETING PURPOSES ("Authorization")

1. I hereby authorize the use and disclosure of all my health information, including but not limited to my personal and medical information contained in the Company's records ("Protected Health Information") to American Retirement Life Insurance Company, Loyal American Life Insurance Company®, Cigna Health and Life Insurance Company, Cigna National Health Insurance Company, and their affiliates ("Company") as described below.
2. I authorize the Company to use the Protected Health Information contained in the Company's records, including its underwriting and claim records, to help determine whether I might be interested in or can benefit from other non-health-related insurance products offered by the Company.
3. I understand that the Company will disclose the Protected Health Information to its underwriting staff, new business staff, sales agents, or marketing management for the purpose of marketing non-health-related products to me.
4. I understand that I may revoke this Authorization at any time, except to the extent that action has been taken by the Company in reliance on this Authorization, by sending a written revocation to the Company's Privacy Steward at PO Box 5700, Scranton, PA 18505-5700.
5. I understand that the Protected Health Information which the Company will use and disclose under this Authorization is not necessary for the Company to determine my eligibility for coverage under the policy and that the Company will not condition its approval and issuance of the policy on my providing this Authorization.
6. I understand that if the person or entity that receives my Protected Health Information is not a health care provider or health plan covered by the federal privacy regulations, the information may be redisclosed by such person or entity and will likely no longer be protected by the federal privacy regulations.
7. I understand that a photocopy, facsimile copy, or other electronic copy of this Authorization is as effective and valid as the original. I also understand that I or my personal representative am entitled to receive a copy of this Authorization. This Authorization will remain in effect for two (2) years from the day my policy(ies) is terminated or the day I revoke my permission.
8. By providing my telephone number(s) on the attached application for insurance, I consent to receive calls, texts, or autodialed or prerecorded telemarketing messages from Cigna and its affiliates.

If you are the representative of a Consumer, describe the scope of your authority to act on the Consumer's behalf:

_____

Applicant A Name

Applicant A Signature **Date**

Name of Applicant A Personal Representative, if applicable

Relationship of Personal Representative to Applicant A

Signature of Personal Representative **Date**

Applicant B Name

Applicant B Signature **Date**

Name of Applicant B Personal Representative, if applicable

Relationship of Personal Representative to Applicant B

Signature of Company's Agent **Date**

Signature of Personal Representative **Date**

A signed copy of this form will be provided to you.

Instructions to Agent: This form is provided for the purpose of compliance with regulations regarding the replacement of Medicare Supplement insurance. When the replacement question on the application is answered "Yes," this form must be dated, signed by the Applicant and by the Agent, and submitted to the Cigna National Health Insurance Company (CNHIC) with the application.

A copy of this form must also be left with the Applicant.

NOTICE TO APPLICANT REGARDING REPLACEMENT OF MEDICARE SUPPLEMENT INSURANCE OR MEDICARE ADVANTAGE

CIGNA NATIONAL HEALTH INSURANCE COMPANY
PO Box 5725, Scranton, PA 18505 • 866-459-4272

SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE.

According to your application, you intend to terminate existing Medicare Supplement or Medicare Advantage insurance and replace it with a policy to be issued by Cigna National Health Insurance Company. Your new policy will provide thirty (30) days within which you may decide without cost whether you desire to keep the policy.

You should review this new coverage carefully. Compare it with all accident and sickness coverage you now have. If, after due consideration, you find that the purchase of this Medicare Supplement coverage is a wise decision, you should terminate your present Medicare Supplement or Medicare Advantage coverage. You should evaluate the need for other accident and sickness coverage you have that may duplicate this policy.

STATEMENT TO APPLICANT BY ISSUER, AGENT, OR BROKER

I have reviewed your current medical or health insurance coverage. To the best of my knowledge, this Medicare Supplement policy will not duplicate your existing Medicare Supplement or, if applicable, Medicare Advantage coverage because you intend to terminate your existing Medicare Supplement coverage or leave your Medicare Advantage plan. The replacement coverage is being purchased for the following reason (check one):

Applicant A

- ☐ additional benefits
- ☐ no change in benefits, but lower premiums
- ☐ fewer benefits and lower premiums
- ☐ my plan has outpatient prescription drug coverage and I am enrolling in Part D
- ☐ disenrollment from a Medicare Advantage plan; please explain reason for disenrollment
- ☐ other (please specify) _____

_____

Applicant B

- ☐ additional benefits
- ☐ no change in benefits, but lower premiums
- ☐ fewer benefits and lower premiums
- ☐ my plan has outpatient prescription drug coverage and I am enrolling in Part D
- ☐ disenrollment from a Medicare Advantage plan; please explain reason for disenrollment
- ☐ other (please specify) _____

_____

If you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical and health history. Failure to include all material medical information on an application may provide a basis for the Company to deny any future claims and to refund your premiums as though your policy had never been in force. After the application has been completed and before you sign it, review it carefully to be certain that all information has been properly recorded.

DO NOT CANCEL YOUR PRESENT POLICY UNTIL YOU HAVE RECEIVED YOUR NEW POLICY AND ARE SURE YOU WANT TO KEEP IT.

_____ _____
Agent/Broker printed name and signature **Date**

_____ _____
Applicant A signature **Date**

_____ _____
Applicant B signature **Date**

Instructions to Agent: This form is provided for the purpose of compliance with regulations regarding the replacement of Medicare Supplement insurance. When the replacement question on the application is answered "Yes," this form must be dated, signed by the Applicant and by the Agent, and submitted to the Cigna National Health Insurance Company (CNHIC) with the application.

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- ☐ disenrollment from a Medicare Advantage plan; please explain reason for disenrollment
- ☐ other (please specify) _____

_____

Applicant B

- ☐ additional benefits
- ☐ no change in benefits, but lower premiums
- ☐ fewer benefits and lower premiums
- ☐ my plan has outpatient prescription drug coverage and I am enrolling in Part D
- ☐ disenrollment from a Medicare Advantage plan; please explain reason for disenrollment
- ☐ other (please specify) _____

_____

If you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical and health history. Failure to include all material medical information on an application may provide a basis for the Company to deny any future claims and to refund your premiums as though your policy had never been in force. After the application has been completed and before you sign it, review it carefully to be certain that all information has been properly recorded.

DO NOT CANCEL YOUR PRESENT POLICY UNTIL YOU HAVE RECEIVED YOUR NEW POLICY AND ARE SURE YOU WANT TO KEEP IT.

_____ _____
Agent/Broker printed name and signature **Date**

_____ _____
Applicant A signature **Date**

_____ _____
Applicant B signature **Date**

DISCRIMINATION IS AGAINST THE LAW

Medicare Supplement coverage

Cigna complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Cigna does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Cigna:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact customer service at the toll-free number shown on your ID card or call 1.866.459.4272 (TTY: Dial 711), and ask a Customer Service Associate for assistance.

If you believe that Cigna has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance by sending an email to ACAGrievance@Cigna.com or by writing to the following address:

Cigna
Nondiscrimination Complaint Coordinator
PO Box 188016
Chattanooga, TN 37422

If you need assistance filing a written grievance, please call 1.866.459.4272 (TTY: Dial 711), or send an email to ACAGrievance@Cigna.com. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, DC 20201
1.800.868.1019, 800.537.7697 (TDD)
Complaint forms are available at
http://www.hhs.gov/ocr/office/file/index.html.

Proficiency of Language Assistance Services

English – ATTENTION: Language assistance services, free of charge, are available to you. For current Cigna customers, call the number on the back of your ID card. Otherwise, call 1.866.459.4272 (TTY: Dial 711).

Spanish – ATENCIÓN: Hay servicios de asistencia de idiomas, sin cargo, a su disposición. Si es un cliente actual de Cigna, llame al número que figura en el reverso de su tarjeta de identificación. Si no lo es, llame al 1.866.459.4272 (los usuarios de TTY deben llamar al 711).

Chinese – 注意：我們可為您免費提供語言協助服務。對於 Cigna 的現有客戶，請致電您的 ID 卡背面的號碼。其他客戶請致電 1.866.459.4272（聽障專線：請撥 711）。

Vietnamese – XIN LƯU Ý: Quý vị được cấp dịch vụ trợ giúp về ngôn ngữ miễn phí. Dành cho khách hàng hiện tại của Cigna, vui lòng gọi số ở mặt sau thẻ Hội viên. Các trường hợp khác xin gọi số 1.866.459.4272 (TTY: Quay số 711).

Korean – 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 현재 Cigna 가입자님들께서는 ID 카드 뒷면에 있는 전화번호로 연락해주십시오. 기타 다른 경우에는 1.866.459.4272 (TTY: 다이얼 711)번으로 전화해주십시오.

Tagalog – PAUNAWA: Makakakuha ka ng mga serbisyo sa tulong sa wika nang libre. Para sa mga kasalukuyang customer ng Cigna, tawagan ang numero sa likuran ng iyong ID card. O kaya, tumawag sa 1.866.459.4272 (TTY: I-dial ang 711).

Russian – ВНИМАНИЕ: вам могут предоставить бесплатные услуги перевода. Если вы уже участвуете в плане Cigna, позвоните по номеру, указанному на обратной стороне вашей идентификационной карточки участника плана. Если вы не являетесь участником одного из наших планов, позвоните по номеру 1.866.459.4272 (TTY: 711).

Arabic – برجاء الانتباه خدمات الترجمة المجانية متاحة لكم. لعملاء Cigna الحاليين برجاء الاتصال بالرقم المدون علي ظهر بطاقتكم الشخصية. او اتصل ب 1.866.459.4272 (TTY: اتصل ب 711).

French Creole – ATANSYON: Gen sèvis èd nan lang ki disponib gratis pou ou. Pou kliyan Cigna yo, rele nimewo ki dèyè kat ID ou. Sinon, rele nimewo 1.866.459.4272 (TTY: Rele 711).

French – ATTENTION: Des services d'aide linguistique vous sont proposés gratuitement. Si vous êtes un client actuel de Cigna, veuillez appeler le numéro indiqué au verso de votre carte d'identité. Sinon, veuillez appeler le numéro 1.866.459.4272 (ATS : composez le numéro 711).

Portuguese – ATENÇÃO: Tem ao seu dispor serviços de assistência linguística, totalmente gratuitos. Para clientes Cigna atuais, ligue para o número que se encontra no verso do seu cartão de identificação. Caso contrário, ligue para 1.866.459.4272 (Dispositivos TTY: marque 711).

Polish – UWAGA: w celu skorzystania z dostępnej, bezpłatnej pomocy językowej, obecni klienci firmy Cigna mogą dzwonić pod numer podany na odwrocie karty identyfikacyjnej. Wszystkie inne osoby prosimy o skorzystanie z numeru 1.866.459.4272 (TTY: wybierz 711).

Japanese – 注意事項：日本語を話される場合、無料の言語支援サービスをご利用いただけます。現在のCignaのお客様は、IDカード裏面の電話番号まで、お電話にてご連絡ください。その他の方は、1.866.459.4272（TTY: 711）まで、お電話にてご連絡ください。

Italian – ATTENZIONE: Sono disponibili servizi di assistenza linguistica gratuiti. Per i clienti Cigna attuali, chiamare il numero sul retro della tessera di identificazione. In caso contrario, chiamare il numero 1.866.459.4272 (utenti TTY: chiamare il numero 711).

German – ACHTUNG: Die Leistungen der Sprachunterstützung stehen Ihnen kostenlos zur Verfügung. Wenn Sie gegenwärtiger Cigna-Kunde sind, rufen Sie bitte die Nummer auf der Rückseite Ihrer Krankenversicherungskarte an. Andernfalls rufen Sie 1.866.459.4272 an (TTY: Wählen Sie 711).

Persian (Farsi) – توجه: خدمات کمک زبانی، به صورت رایگان به شما ارائه می‌شود. برای مشتریان فعلی Cigna، لطفاً با شماره‌ای که در پشت کارت شناسایی شماست تماس بگیرید. در غیر اینصورت با شماره 1.866.459.4272 تماس بگیرید (شماره تلفن ویژه ناشنوایان: شماره 711 را شماره‌گیری کنید).