Enrollment / Change Form (Consolidated)

Employer: Complete Section A
Employee: Complete Sections B-G

Insured and/or Administered by
Connecticut General Life Insurance Company
CIGNA HealthCare

CIGNA®

Please print and thank you for providing this information

A

☐ OPEN ENROLL. ☐ CHANGE ☐ NEW ENROLL. ☐ REINSTATE	EFFECTIVE DATE OF ADD/CHANGE/ CANCELLATION (MM/DD/CCYY)	EMPLOYER NAME	EMPLOYER ADDRESS

CIGNA ACCOUNT NO.	DIVISION/BRANCH/LOCATION/CLASS	DATE OF HIRE (MM/DD/CCYY)	NETWORK ID	BRANCH CODE	CDH GROUP NO.	MEDICAL BEN. OPTION	DENTAL BEN. OPTION	CIGNA CHOICE FUND ANNUAL AMOUNT

TYPE OF CHANGE:

- ☐ **Add Dependent(s)** * Date: ____
- ☐ **Cancel Employee** Last Date of Coverage: ____
- ☐ **Cancel Dependent(s)** * Last Date of Coverage: ____
- ☐ **Address Change**
- ☐ **Transfer to COBRA** ☐ 18 mos. ☐ 29 mos. ☐ 36 mos.
- ☐ **Family Security Benefit/Surviving Spouse**
- ☐ **Retirement**
- ☐ **Other** ____

*** List Names in Section B**

B

EMPLOYEE NAME *(Last)*	*(First)*	*(M.I.)*	SOCIAL SECURITY NO.

EMPLOYEE DATE OF BIRTH (MM/DD/CCYY)	HOME PHONE	WORK PHONE	HOME E-MAIL ADDRESS	EMPLOYEE IDENTIFICATION NUMBER
	( )	( )		

ADDRESS *(Street)*	*(City)*	*(State)*	*(Zip Code)*

I WOULD LIKE COVERAGE FOR ME AND MY DEPENDENTS. *(Specify last name if different from yours)* Last Name / First Name / M.I.	DEPENDENT SOCIAL SECURITY NO.	DATE OF BIRTH MM DD CCYY	GEN-DER	COVERAGE SELECTION	FULL TIME STUDENT? * Yes No	*If you choose a Managed Care Medical Option: Select your choice of Primary Care Physician (PCP) or HealthCare Center (HCC) and enter the ID Numbers below. Note: PCP selection is optional for Open Access Plans.*	EXISTING PATIENT? 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		PCP or HCC Choice -	☐ ☐	1st Choice - / 2nd Choice -	☐ ☐ / ☐ ☐	☐ Add ☐ Cancel
Spouse			☐ M ☐ F	☐ Medical ☐ Dental		PCP or HCC Choice -	☐ ☐	1st Choice - / 2nd Choice -	☐ ☐ / ☐ ☐	☐ Add ☐ Cancel
Dependent * Relationship			☐ M ☐ F	☐ Medical ☐ Dental	☐ ☐	PCP or HCC Choice -	☐ ☐	1st Choice - / 2nd Choice -	☐ ☐ / ☐ ☐	☐ Add ☐ Cancel
Dependent * Relationship			☐ M ☐ F	☐ Medical ☐ Dental	☐ ☐	PCP or HCC Choice -	☐ ☐	1st Choice - / 2nd Choice -	☐ ☐ / ☐ ☐	☐ Add ☐ Cancel
Dependent * Relationship			☐ M ☐ F	☐ Medical ☐ Dental	☐ ☐	PCP or HCC Choice -	☐ ☐	1st Choice - / 2nd Choice -	☐ ☐ / ☐ ☐	☐ Add ☐ Cancel

*** DEPENDENTS** - If full time student and age 19 or over, attach proof verifying credit hours. If totally disabled prior to age 19, attach proof of disability for eligibility review.

C

MANAGED CARE MEDICAL OPTIONS:

- ☐ Point-of-Service (or DPP or CHA)
- ☐ HMO
- ☐ Network (or EPP)
- ☐ Point-of-Service Open Access
- ☐ HMO Open Access
- ☐ Network Open Access
- ☐ Open Access Plus
- ☐ Open Access Plus In-Network

OTHER MEDICAL OPTIONS:

- ☐ Preferred Provider Option (PPO)
- ☐ In-Network PPO or EPO
- ☐ Preferred Provider Access (PPA)
- ☐ Medical Indemnity
- ☐ ____

CIGNA CHOICE FUND℠ OPTIONS:

- ☐ HRA
- ☐ HSA
- ☐ Pharmacy HRA
- ☐ Dental HRA
- ☐ with PPO
- ☐ with Open Access Plus
- ☐ with Open Access Plus In-Network
- ☐ with EPO
- ☐ with Indemnity

- ☐ CIGNA Care Network
- ☐ Decline Coverage

OPTION # *(if applicable)*: ☐ 1 ☐ 2 ☐ 3

If you choose a Managed Care Medical Option other than Open Access Plus, print the name of the CIGNA HealthCare network. (See the cover or first page of the physician directory). Include the name of the city and state.

CIGNA HealthCare of (city/state):

D

FLEXIBLE SPENDING ACCOUNT OPTIONS:

- ☐ Health Care*
- ☐ Dependent Day Care*
- ☐ Decline Coverage

E

DENTAL OPTIONS:

- ☐ CIGNA Dental Care (CDC)
- ☐ Dental PPO
- ☐ Dental EPO
- ☐ Dental Indemnity
- ☐ Decline Coverage

*If you have checked off one of the Flexible Spending Accounts in Section D, please make sure you have completed the corresponding enrollment form included in this package.

F

OTHER HEALTH CARE 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 NO.	EFFECTIVE DATE	MEDICARE Part A	MEDICARE Part B	MEDICAID	OTHER INSURANCE CARRIER
			☐	☐	☐	☐
			☐	☐	☐	☐

G

SIGNATURE - 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'S SIGNATURE / DATE	SPOUSE'S SIGNATURE / DATE	EMPLOYER'S SIGNATURE / DATE

IMPORTANT! BEFORE YOU WRITE ON THIS SIDE:
DETACH THIS PAGE BEFORE COMPLETING SECTIONS H AND I

Employee: Complete Sections H-I if applicable

H

LIFE AND AD&D	EMPLOYEE	DEPENDENT
☐ Life	$	
☐ Additional Life	$	
☐ Dependent Life - Spouse		$
☐ Dependent Life - Child(ren)		$
☐ Accidental Death & Dismemberment (AD&D)	$	
☐ Additional AD&D	$	

STD AND LTD	EMPLOYEE
☐ Short Term Disability (STD)	$
☐ Long Term Disability (LTD)	$

Decline Coverage: ☐ LIFE ☐ AD&D ☐ STD ☐ LTD

I

IF YOU ELECT LIFE OR AD&D BENEFITS, INDICATE YOUR BENEFICIARY BELOW.

BENEFICIARY NAME *(Last)*	*(First)*	*(M.I.)*	RELATIONSHIP	% OF INSURANCE

IMPORTANT: If you have chosen medical coverage and your employer is providing Life and/or AD&D coverage, please forward a copy of this page, along with the first ply of this form as your employer directs.

PROVISIONS

- "CIGNA HealthCare" refers to various operating subsidiaries of CIGNA Corporation. Products and services are provided by these subsidiaries and not by CIGNA Corporation. These subsidiaries include Connecticut General Life Insurance Company, Tel-Drug, Inc. and its affiliates, CIGNA Behavioral Health, Inc., Intracorp, and HMO or service company subsidiaries of CIGNA Health Corporation and CIGNA Dental Health, Inc.
- I agree, for myself and my dependents, that, in the event any health services provided are the primary responsibility of any other party by way of other group health coverage or by the act or omission of another person to fully inform the healthplan and will execute such assignments, liens or other documents which may be necessary to enable the healthplan to recover the value of the services provided. I further agree that in the event I or any of my dependents collect benefits or damages from any other party who has primary responsibility for services provided by the healthplan, I will immediately reimburse the healthplan to the extent of services provided, to the extent permitted by state law.

FRAUD WARNING

Any person who, knowingly and with intent to defraud any insurance company or other person: (1) files an application for insurance or statement of claim containing any materially false information; or (2) conceals for the purpose of misleading, information concerning any material fact thereto, commits a fraudulent insurance act.

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 PROVISION FOR EMPLOYERS WITH SECTION 125 PLANS

By allowing an individual to enroll in the Insurance Plan other than during the open enrollment period, CIGNA HealthCare or Connecticut General Life Insurance Company does not waive any terms of its contract. Further, by allowing an individual to enroll in the Insurance Plan other than during an open enrollment period, CIGNA HealthCare or Connecticut General Life Insurance Company does 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.