Enrollment / Change Form (Consolidated)

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

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 (MM/DD/CCYY)	EMPLOYER NAME	CIGNA ACCOUNT NO.	DIVISION / BRANCH / LOCATION / CLASS	DATE OF HIRE (MM/DD/CCYY)	NETWORK ID / HMO CODE

TYPE OF CHANGE:
- ☐ **Add Dependent(s) ***
  - ☐ Birth ☐ Marriage
  - ☐ Adoption Placement
  - ☐ Other
  - Date: ____________
- ☐ **Cancel Employee**
  - ☐ Termination of Employment
  - ☐ Other Insurance
  - ☐ Other ____________
- ☐ **Address Change**
- ☐ **Cancel Dependent(s) ***
  - ☐ Marriage ☐ Divorce
  - ☐ Change in Student Status
  - ☐ Other ____________
- *** List Names in Section B**
- ☐ **Transfer to COBRA**
  - ☐ 18 mos.
  - ☐ 29 mos.
  - ☐ 36 mos.
- ☐ **Family Security Benefit / Surviving Spouse**
- ☐ **Retirement**
- ☐ **Other** ____________

GROUP / DIV. NO.	CDH GROUP NO.
MEDICAL BEN. OPTION	**DENTAL BEN. OPTION**

B

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

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.	DATE OF BIRTH MM DD CCYY	SEX	COVERAGE SELECTION Medical	COVERAGE SELECTION Dental	FULL TIME STUDENT? * Yes	FULL TIME STUDENT? * No	*If you choose a Managed Care Medical Option: Select your 1st and 2nd choice of Primary Care Physician (PCP) or HealthCare Center (HCC) and enter the ID Numbers below.*	EXISTING PATIENT? Yes	EXISTING PATIENT? No	*If you choose the CIGNA Dental Care or CIGNA Dental Access Option: Enter your 1st and 2nd choice of Dental Office Number below.*	EXISTING PATIENT? Yes	EXISTING PATIENT? No
Employee		☐ M	☐	☐			1st Choice -	☐	☐	1st Choice -	☐	☐
		☐ F					2nd Choice -	☐	☐	2nd Choice -	☐	☐
Spouse		☐ M	☐	☐			1st Choice -	☐	☐	1st Choice -	☐	☐
		☐ F					2nd Choice -	☐	☐	2nd Choice -	☐	☐
Dependent * Relationship		☐ M	☐	☐	☐	☐	1st Choice -	☐	☐	1st Choice -	☐	☐
		☐ F					2nd Choice -	☐	☐	2nd Choice -	☐	☐
Dependent * Relationship		☐ M	☐	☐	☐	☐	1st Choice -	☐	☐	1st Choice -	☐	☐
		☐ F					2nd Choice -	☐	☐	2nd Choice -	☐	☐
Dependent * Relationship		☐ M	☐	☐	☐	☐	1st Choice -	☐	☐	1st Choice -	☐	☐
		☐ F					2nd Choice -	☐	☐	2nd Choice -	☐	☐

*** 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:
- ☐ FlexCare Point of Service (DPP)
- ☐ FlexCare (EPP)
- ☐ Point of Service (CHA)
- ☐ HMO (CHC)

OTHER MEDICAL OPTIONS:
- ☐ Preferred Provider Option (PPO)
- ☐ Preferred Provider Access (PPA)
- ☐ Medical Indemnity
- ☐ ____________
- ☐ Decline Coverage

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

If you choose a Managed Care Medical Option, print the name of the CIGNA HealthCare Network. (See the cover or first page of the physician guide). Include the name of the city and state.

CIGNA HealthCare of (city / state):

D

DENTAL OPTIONS:
- ☐ CIGNA Dental Care (CDC)
- ☐ CIGNA Dental Access (CDA)
- ☐ Dental PPO
- ☐ Dental Indemnity
- ☐ Decline Coverage

E

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.	EMPLOYER	INSURANCE COMPANY NAME AND ADDRESS	MEDICARE Part A	MEDICARE Part B
				☐	☐
				☐	☐

Have you or your dependent(s) ever been covered by a CIGNA HealthCare Network? ☐ Yes ☐ No
If yes, Name of Person Covered ____________
Social Security No. ____________ Covered As: ☐ Employee ☐ Dependent
Name of Healthplan: CIGNA HealthCare of: ____________ *(city / state)*

F

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

DISTRIBUTION: Original: CIGNA HealthCare / Eligibility Services **2nd Ply:** CIGNA Eligibility Services / CDH / Dental Claim Office **3rd Ply:** Employee **4th Ply:** Employer

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

Employee: Complete Sections G-H if applicable

G

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

H

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 either the Commercial Point of Service (CHA) or the Commercial HMO option and your employer is providing Life and/or AD&D, please forward a copy of this page, along with the first ply of this form.

PROVISIONS

AUTHORIZATION TO DISCLOSE CONFIDENTIAL INFORMATION AND FRAUD NOTICE

- I understand that after I enroll, CIGNA HealthCare or Connecticut General Life Insurance Company may need to obtain Confidential Information. I also understand that CIGNA HealthCare or Connecticut General Life Insurance Company may need to provide this Confidential Information to others. Any person or entity having Confidential Information has my permission to provide this Confidential Information upon request to CIGNA HealthCare or Connecticut General Life Insurance Company, any CIGNA HealthCare or Connecticut General Life Insurance Company participating provider, or any other provider or entity performing a service for the purpose of plan administration, the performance of any CIGNA HealthCare or Connecticut General Life Insurance Company program or operations, or to assess the quality of and access to health care services and supplies. CIGNA HealthCare or Connecticut General Life Insurance Company has my permission to give any Confidential Information to any person, company or entity when it determines that such disclosure is necessary or appropriate for the administration of the plan, the performance of CIGNA HealthCare or Connecticut General Life Insurance Company programs or operations, assessing quality and accessibility of health care services and supplies, or reporting to third parties involved in plan administration. I am making this authorization for myself and as the agent or representative of my spouse and any dependent children. I understand that it will remain in effect until I send written notice revoking it to CIGNA HealthCare or Connecticut General Life Insurance Company or for such shorter period as required by law. Until revoked, this authorization may be relied upon by CIGNA HealthCare or Connecticut General Life Insurance Company and other parties. "Confidential Information" means, with respect to me and any covered dependents, any medical, dental, mental health, substance abuse, communicable disease, AIDS and HIV related information and disability or employment related information. CIGNA HealthCare or Connecticut General Life Insurance Company means the CIGNA companies involved in the administration of the plan.
- Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subject such person to criminal and civil penalties.

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.

APPLICABLE TO HMO BENEFITS

- CIGNA HealthCare provides HMO coverage under agreements with your employer, and provides the HMO coverage under CIGNA HEALTH ACCESS.
- CIGNA HealthCare provides HMO services to its members and also makes its networks available to Connecticut General Life Insurance Company Flexcare enrollees.
- 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.

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.

SPECIAL STATE PROVISIONS

- **CA Residents Only:** The Healthplan uses binding arbitration to settle disputes, including claims of medical malpractice and disputes relating to the delivery of service under the plan. It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review or arbitration proceedings. The parties to this contract, by entering into it, are giving up their constitutional right to have any dispute decided in a court of law before a jury, and instead are accepting the use of arbitration. It is understood that this agreement to arbitrate shall apply and extend to any dispute for medical malpractice, relating to the delivery of service under the plan, and to any claims in tort, contract or otherwise, between Group, any individual(s) seeking services under the plan, whether referred to as a Member, Subscriber, Dependent, Enrollee or otherwise (whether a minor or an adult), or the heirs-at-law or personal representatives of any such individual(s), as the case may be, and the Healthplan (including any of their agents, successors- or predecessors-in-interest, employees, or providers).
- **Kansas Residents Only:** 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 applicable state law.
- **Mid-Atlantic:** A referral from the enrollee's Primary Care Physician is not required for routine gynecological care received from a network gynecologist, out-of-area emergency-urgent care, or out of network care received under the Point of Service option.
- **Georgia:** If you were a former patient of a designated doctor and are now considering selecting that doctor, you are considered a "new patient". I hereby apply for membership in CIGNA HealthCare of Georgia, Inc. or Connecticut General Life Insurance Company and authorize my employer/union/association to deduct any required contribution from earnings. I hereby authorize any physician, hospital, insurer or other organization or person have in any records, data or information concerning health history or medical insurance for me or my family members to furnish such records, data, or information as may be requested by CIGNA HealthCare of Georgia, Inc. or Connecticut General Life Insurance Company, or their duly authorized representative. A photocopy of this authorization shall be considered as effective and valid as the original. CIGNA HealthCare or Connecticut General Life Insurance Company must be notified of all changes. I authorize that payment be made under Part B of Medicare to CIGNA HealthCare of Georgia, Inc. or Connecticut General Life Insurance Company for medical and other services furnished me for which it pays or had paid.