

Enrollment / Change Form (Consolidated)

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

Insured and/or Administered by
Cigna Health and Life Insurance Company
Cigna HealthCare



Please print and thank you for providing this information

A	<input type="checkbox"/> OPEN ENROLL. <input type="checkbox"/> CHANGE <input type="checkbox"/> NEW ENROLL. <input type="checkbox"/> REINSTATE		EFFECTIVE DATE OF ADD/CHANGE/ CANCELLATION (MM/DD/CCYY)		EMPLOYER NAME		EMPLOYER ENTITY				
							<input type="checkbox"/> Government <input type="checkbox"/> School <input type="checkbox"/> Jail <input type="checkbox"/> Library				
CIGNA ACCOUNT NO.		DIVISION/BRANCH/LOCATION/CLASS		DATE OF HIRE (MM/DD/CCYY)		BRANCH CODE		MEDICAL BEN. OPTION		VISION BEN. OPTION	
TYPE OF CHANGE: <input type="checkbox"/> Add Dependent(s) * Date: _____ <input type="checkbox"/> Address Change <input type="checkbox"/> Family Security Benefit/Surviving Spouse <input type="checkbox"/> Cancel Employee Last Date of Coverage: _____ <input type="checkbox"/> Transfer to COBRA <input type="checkbox"/> Retirement <input type="checkbox"/> Cancel Dependent(s) * Last Date of Coverage: _____ <input type="checkbox"/> 18 mos. <input type="checkbox"/> 29 mos. <input type="checkbox"/> 36 mos. <input type="checkbox"/> Other _____ * List Names in Section 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 _____	
MAILING ADDRESS (Street) _____				(City) _____				(State) _____		(Zip Code) _____	
I WOULD LIKE COVERAGE FOR ME AND MY DEPENDENTS. (Specify last name if different from yours)			DEPENDENT SOCIAL SECURITY NO.	DATE OF BIRTH	GENDER	COVERAGE SELECTION	FULL TIME STUDENT? *	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?	(check one)
Last Name	First Name	M.I.		MM DD CCYY			Yes No			Yes No	
Employee					<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Med. <input type="checkbox"/> Vis.			PCP or HCC Choice -	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> Add <input type="checkbox"/> Cancel
Spouse					<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Med. <input type="checkbox"/> Vis.			PCP or HCC Choice -	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> Add <input type="checkbox"/> Cancel
Dependent *			Relationship		<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Med. <input type="checkbox"/> Vis.	<input type="checkbox"/> <input type="checkbox"/>		PCP or HCC Choice -	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> Add <input type="checkbox"/> Cancel
Dependent *			Relationship		<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Med. <input type="checkbox"/> Vis.	<input type="checkbox"/> <input type="checkbox"/>		PCP or HCC Choice -	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> Add <input type="checkbox"/> Cancel
Dependent *			Relationship		<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Med. <input type="checkbox"/> Vis.	<input type="checkbox"/> <input type="checkbox"/>		PCP or HCC Choice -	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> Add <input type="checkbox"/> Cancel

C MEDICAL OPTIONS: <input type="checkbox"/> Premium Open Access Plus <input type="checkbox"/> CDHP Open Access Plus <input type="checkbox"/> Standard Open Access Plus <input type="checkbox"/> Decline Coverage	D FLEXIBLE SPENDING ACCOUNT OPTIONS: <input type="checkbox"/> Health Care* <input type="checkbox"/> Dependent Day Care* <input type="checkbox"/> Decline Coverage Health Care® FSA Annual Employee Contribution Election Amount: _____ Dependent Day Care® FSA Annual Employee Contribution Election Amount: _____ THE FSA AMOUNT LISTED IS: not eligible if enrolled in HSA plan; max contribution: \$2,600. THE FSA AMOUNT LISTED IS: all plans eligible; max contribution: \$5,000.	E VISION OPTIONS: <input type="checkbox"/> Cigna Vision Basic <input type="checkbox"/> Decline Coverage <input type="checkbox"/> Cigna Vision Supplemental
---	--	---

*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? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please provide the following:															
NAME OF PERSON COVERED		SOCIAL SECURITY NO.		EFFECTIVE DATE		MEDICARE Part A		MEDICARE Part B		MEDICARE ID #		MEDICAID		OTHER INSURANCE CARRIER	
						<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>	
						<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>	

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

PROVISIONS

- "Cigna HealthCare" refers to the various HMO or service company subsidiaries of Cigna Health Corporation and Cigna Dental Health, Inc. HMO plans are offered by Cigna HealthCare of Arizona, Inc., Cigna HealthCare of California, Inc., Cigna HealthCare of Colorado, Inc., Cigna HealthCare of Connecticut, Inc., Cigna HealthCare of Florida, Inc., Cigna HealthCare of Georgia, Inc., Cigna HealthCare of Illinois, Inc. (IL & IN), Cigna HealthCare of Indiana, Inc., Cigna HealthCare of St. Louis, Inc. (MO, KS, IL), Cigna HealthCare of North Carolina, Inc., Cigna HealthCare of New Jersey, Inc., Cigna HealthCare of South Carolina, Inc., Cigna HealthCare of Tennessee, Inc. (TN & MS), and Cigna HealthCare of Texas, Inc.
- The term "DHMO" is used to refer to product designs that may differ by state of residence of enrollee, including but not limited to, prepaid plans, managed care plans, and plans with open access features.
- The DHMO (Cigna Dental Care) plan is underwritten or administered by Cigna Health and Life Insurance Company, Cigna HealthCare of Connecticut, Inc. or Cigna Dental Health, Inc. and its operating subsidiaries, including Cigna Dental Health Plan of Arizona, Inc., Cigna Dental Health of California, Inc., Cigna Dental Health of Colorado, Inc., Cigna Dental Health of Delaware, Inc., Cigna Dental Health of Florida, Inc., **a Prepaid Limited Health Services Organization licensed under Chapter 636, Florida Statutes**, Cigna Dental Health of Kansas, Inc. (KS & NE), Cigna Dental Health of Kentucky, Inc., Cigna Dental Health of Maryland, Inc., Cigna Dental Health of Missouri, Inc., Cigna Dental Health of New Jersey, Inc., Cigna Dental Health of North Carolina, Inc., Cigna Dental Health of Ohio, Inc., Cigna Dental Health of Pennsylvania, Inc., Cigna Dental Health of Texas, Inc., and Cigna Dental Health of Virginia, Inc.
- The Cigna Dental PPO, EPO and Traditional plans are underwritten or administered by Cigna Health and Life Insurance Company, with network management services provided by Cigna Dental Health, Inc. and certain of its operating subsidiaries.
- I agree, for myself and my covered 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, I will fully inform the health plan and will execute such assignments, liens or other documents which may be necessary to enable the health plan to recover the value of the services provided. I further agree that in the event I or any of my covered dependents collect benefits or damages from any other party who has primary responsibility for services provided by the health plan, I will immediately reimburse the health plan to the extent of services provided and 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 PROVISIONS FOR EMPLOYERS WITH SECTION 125 PLANS

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

"Cigna," the "Tree of Life" logo, "Cigna Choice Fund," "LocalPlus," "Cigna Care Network" and "Cigna Dental Care" are registered service marks, and "Cigna HealthCare" is a service mark, of Cigna Intellectual Property, Inc., licensed for use by Cigna Corporation and its operating subsidiaries. All products and services are provided by or through such operating subsidiaries and not by Cigna Corporation. Such operating subsidiaries include Connecticut General Life Insurance Company (CGLIC), Cigna Health and Life Insurance Company (CHLIC), and HMO or service company subsidiaries of Cigna Health Corporation and Cigna Dental Health, Inc. In Arizona, HMO plans are offered by Cigna HealthCare of Arizona, Inc. In California, HMO and Network plans are offered by Cigna HealthCare of California, Inc. In Connecticut, HMO plans are offered by Cigna HealthCare of Connecticut, Inc. In North Carolina, HMO plans are offered by Cigna HealthCare of North Carolina, Inc. All other medical plans in these states are insured or administered by CGLIC or CHLIC.