Dental Insurance Changes

To drop dependents:

- Dental Insurance Change Form (Page 2)

To add dependents:

- Dental Insurance Change Form (Page 2)
- Dental Insurance Enrollment Form (Page 3)

To drop dental insurance:

- Dental Insurance Change Form (Page 2)
- Dental Insurance Waiver Form (page 4)

To switch dental insurance:

- Dental Insurance Change Form (Page 2)
- Dental Insurance Enrollment Form (Page 3)

To enroll in a dental insurance plan:

- Dental Insurance Change Form (Page 2)
- Dental Insurance Enrollment Form (Page 3)

Please send completed forms to Kris Akut, Benefits Coordinator.

2022 Dental Insurance Change Form

Last Name:_____ **First Name:**_____

Moody ID #: _____

My CURRENT Dental Insurance is:

None _____

Cigna PPO		**Cigna HMO**	
Employee	_____	Employee	_____
Empl. + 1	_____	Empl. + 1	_____
Family	_____	Family	_____

I am CURRENTLY covering the following dependent(s):

Name of Dependent:_____

Name of Dependent:_____

Name of Dependent:_____

I would like my NEW Dental Insurance to be:

Drop all dental coverage* _____

Cigna PPO**		**Cigna HMO****	
Employee	_____	Employee	_____
Empl. + 1	_____	Empl. + 1	_____
Family	_____	Family	_____

I would like to ADD or DROP the following dependent(s):

☐ **Add**** Name of Dependent:_____ Birth date:_____/_____/_____
☐ **Drop** Relationship to you: _____

☐ **Add**** Name of Dependent:_____ Birth date:_____/_____/_____
☐ **Drop** Relationship to you: _____

☐ **Add**** Name of Dependent:_____ Birth date:_____/_____/_____
☐ **Drop** Relationship to you: _____

Effective Date of Change: 01/01/2022

Signature of Employee:_____ Date:_____/_____/_____

* A completed **Waiver Form** must be turned in with this form
A completed **Enrollment Form must be turned in with this form

Enrollment / Change Form (Consolidated)

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

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

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	VISION BEN. OPTION	CIGNA CHOICE FUND ANNUAL AMOUNT

TYPE OF CHANGE:

☐ Add Dependent(s) * Cancel Employee Cancel Dependent(s) *
Date: _____
Last Date of Coverage: _____
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
	( )	( )		

MAILING 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 Cigna One Health HMO enter the PCP ID Numbers below. Note: PCP selection is optional for Open Access Plans.*	EXISTING PATIENT? Yes No	*If you choose the Cigna Dental HMO Option: Enter your 1st and 2nd choice of Dental Office Number below.*	EXISTING PATIENT? Yes No	*(check one)*
Employee			☐ M ☐ F	☒		PCP or HCC Choice - ☒		1st Choice - 2nd Choice -		☐ Add ☐ Cancel
Spouse			☐ M ☐ F	☒ Dent.		PCP or HCC Choice -		1st Choice - 2nd Choice -		☐ Add ☐ Cancel
Dependent * Relationship			☐ M ☐ F	☒	☐ ☐	PCP or HCC Choice -		1st Choice - 2nd Choice -		☐ Add ☐ Cancel
Dependent * Relationship			☐ M ☐ F	☒	☐ ☐	PCP or HCC Choice - ☒		1st Choice - 2nd Choice -		☐ Add ☐ Cancel
Dependent * Relationship			☐ M ☐ F	☒ Dent.	☐ ☐	PCP or HCC Choice -		1st Choice - 2nd Choice -		☐ Add ☐ Cancel

***DEPENDENTS -** Dependents are covered under the medical plan to age 26. Proof of student status may be required for dental and/or vision coverage. If totally disabled prior to dependent eligibility end date, attach proof of disability for eligibility review.

C

MEDICAL OPTIONS:

☒
☐ Open Access Plus
☐ One Health HMO
☐ High Deductible (HDHP) HSA
☐ Waive Medical

*

D

DENTAL OPTIONS:

☐ DHMO
☐ DPPO

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.	EFFECTIVE DATE	MEDICARE Part A	MEDICARE Part B	MEDICARE ID #	MEDICAID	OTHER INSURANCE CARRIER
			☐	☐		☐	☐
			☐	☐		☐	☐

F

EMPLOYER'S SIGNATURE / DATE

MOODY BIBLE INSTITUTE
DENTAL PLAN WAIVER FORM

This is to certify I have been given the opportunity to examine Moody's group dental benefits available to me and to apply through my Moody and I have decided **NOT** to apply for the group dental benefits for:

☐ Myself ☐ My Dependents

I am waiving coverage at this time because I have coverage under another dental plan: ☐ Yes ☐ No

If yes, please provide the following information in the boxes below:

Name of Insured Person	Birth Date	Employer/Sponsor for Other Insurance	
Other Insurance Company	Address		Plan Number

I further understand, if in the future I decide to apply for group dental benefits, additional limitations and waiting periods may apply.

PLEASE PRINT: Employee Name (First, Initial, Last)	Social Security
Employee Signature for Refusal	Date