Health Insurance Changes

To drop dependents:

- Health Insurance Change Form (Page 2)

To add dependents:

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

To drop health insurance:

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

To switch health insurance:

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

To enroll in a health insurance plan:

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

Please send completed forms to Kris Akut, Benefits Coordinator.

2022 Health Insurance Change Form

Last Name:__________________________________ **First Name:**______________________________

Moody ID #: ________________________

My CURRENT Health Insurance is:

Place an "x" in the field that applies below

None ______

Cigna Open Access Plus		**Cigna Choice Fund HSA**		**Cigna One Health HMO**	
Employee	______	Employee	______	Employee	______
Empl. + Spouse	______	Empl. + Spouse	______	Empl. + 1	______
Empl. + Child(ren)	______	Empl. + Child(ren)	______	Family	______
Family	______	Family	______		

I am CURRENTLY covering the following dependent(s):

Name of Dependent:______________________________

Name of Dependent:______________________________

Name of Dependent:______________________________

I would like my NEW Health Insurance to be:

Place an "x" in the field that applies below

Drop all coverage*______

Cigna Open Access Plus		**Cigna Choice Fund HSA**		**Cigna One Health HMO**	
Employee	______	Employee	______	Employee	______
Empl. + Spouse	______	Empl. + Spouse	______	Empl. + 1	______
Empl. + Child(ren)	______	Empl. + Child(ren)	______	Family	______
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

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 — Date: ____________
☐ Employee Cancel — Last Date of Coverage: ____________
☐ 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
	( )	( )		

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	GENDER	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 Dental Office Number below.*	EXISTING PATIENT? Yes No	*(check one)*
Employee			☐ M ☐ F	X ☐ Med. ☐ Dent.		PCP or HCC Choice -	☐ ☐	X 1st Choice - / 2nd Choice -	☐ ☐ / ☐ ☐	☐ Add ☐ Cancel
Spouse			☐ M ☐ F	X ☐ Med. ☐ Dent.		PCP or HCC Choice -	☐ ☐	X 1st Choice - / 2nd Choice -	☐ ☐ / ☐ ☐	☐ Add ☐ Cancel
Dependent * Relationship			☐ M ☐ F	X ☐ Med. ☐ Dent.	☐ ☐	PCP or HCC Choice -	☐ ☐	X 1st Choice - / 2nd Choice -	☐ ☐ / ☐ ☐	☐ Add ☐ Cancel
Dependent * Relationship			☐ M ☐ F	X ☐ Med. ☐ Dent.	☐ ☐	PCP or HCC Choice -	☐ ☐	X 1st Choice - / 2nd Choice -	☐ ☐ / ☐ ☐	☐ Add ☐ Cancel
Dependent * Relationship			☐ M ☐ F	X ☐ Med. ☐ Dent.	☐ ☐	PCP or HCC Choice -	☐ ☐	X 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
☐ Cigna One Health HMO
☐ Choice Fund (HDHP) HSA

X

*

D

X **DENTAL OPTIONS:**

☐ DHMO
☐ DPPO
☐ Waive Dental

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

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	EMPLOYER'S SIGNATURE / DATE

MOODY BIBLE INSTITUTE
HEALTH PLAN WAIVER FORM

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

☐ Myself ☐ My Dependents

I am waiving coverage at this time because I have coverage under another health 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 health benefits, additional limitations and waiting periods may apply.

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

PROVISIONS

- In the District of Columbia, the DHMO (Cigna Dental Care) plan is underwritten or administered by Cigna Health and Life Insurance Company. The Cigna Dental PPO, EPO and Indemnity plans are underwritten or administered by Cigna Health and Life Insurance Company, with network management services provided by Cigna Dental Health, Inc.

- 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

WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

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.

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