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) *** 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
	( )	( )		

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	☐ Med. ☐ Dent.		PCP or HCC Choice -	☐ ☐	1st Choice - 2nd Choice -	☐ ☐ ☐ ☐	☐ Add ☐ Cancel
Spouse			☐ M ☐ F	☐ Med. ☐ Dent.		PCP or HCC Choice -	☐ ☐	1st Choice - 2nd Choice -	☐ ☐ ☐ ☐	☐ Add ☐ Cancel
Dependent * Relationship			☐ M ☐ F	☐ Med. ☐ Dent.	☐ ☐	PCP or HCC Choice -	☐ ☐	1st Choice - 2nd Choice -	☐ ☐ ☐ ☐	☐ Add ☐ Cancel
Dependent * Relationship			☐ M ☐ F	☐ Med. ☐ Dent.	☐ ☐	PCP or HCC Choice -	☐ ☐	1st Choice - 2nd Choice -	☐ ☐ ☐ ☐	☐ Add ☐ Cancel
Dependent * Relationship			☐ M ☐ F	☐ Med. ☐ 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
☐ Cigna One Health HMO
☐ Choice Fund (HDHP) HSA
☐ Waive Medical

*

D

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

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.