Cigna Dental Enrollment Form

Employer: Complete Section A
Employee: Complete Sections B, C & D

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.**	**DENTAL BENEFIT OPTION**

TYPE OF CHANGE:

- ☐ **Add Dependent(s) *** Date: _____
- ☐ **Cancel Employee** Last Date of Coverage: _____
- ☐ **Cancel Dependent(s) *** Last Date of Coverage: _____
  Reason for Cancellation:
  - ☐ Leave employment
  - ☐ Transfer out of Cigna Dental Care area
  - ☐ Transfer to another plan
- ☐ **Address Change**
- ☐ **Transfer to COBRA**
  - ☐ 18 mos. ☐ 29 mos. ☐ 36 mos.
- ☐ **Other** _____

*** List Names in Section C**

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
ADDRESS *(Street)*	*(City)*		*(State)*	*(Zip Code)*

WHAT IS YOUR PRIMARY LANGUAGE? *(optional)*	DO YOU HAVE A DISABILITY AFFECTING YOUR ABILITY TO COMMUNICATE OR READ? *(optional)* ☐ Yes ☐ No	SELECT PLAN: ☐ Cigna Dental Care® ☐ Cigna Dental EPO ☐ Cigna Dental PPO ☐ Cigna Traditional

C

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	FULL-TIME STUDENT? Yes No	DENTAL OFFICE SELECTION *(for Cigna Dental Care only)*	START DATE OF CONTINUOUS DENTAL COVERAGE *(for Cigna Dental PPO only)* (Month, Day, Year)	*(check one)*
Employee			☐ M ☐ F		1st Choice - 2nd Choice -		☐ Add ☐ Cancel
Spouse			☐ M ☐ F		1st Choice - 2nd Choice -		☐ Add ☐ Cancel
Dependent Relationship			☐ M ☐ F	☐ ☐	1st Choice - 2nd Choice -		☐ Add ☐ Cancel
Dependent Relationship			☐ M ☐ F	☐ ☐	1st Choice - 2nd Choice -		☐ Add ☐ Cancel
Dependent Relationship			☐ M ☐ F	☐ ☐	1st Choice - 2nd Choice -		☐ Add ☐ Cancel

Proof of student or handicapped status for overage dependents may be required.
The original effective date must be completed for each member in order for continuous coverage credit to be applied toward waiting period.

D

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

NOTE: Not all products are available for all clients or all states. Check your enrollment materials carefully to see what is offered for your group.

DISTRIBUTION: White - Cigna **Canary -** Member **Pink -** Employer