Insured and/or Administered by
Connecticut General Life Insurance Company
CIGNA HealthCare

Enrollment / Change Form

Employer: Complete SHADED sections
Employee: Complete NON-SHADED sections

A				
☐New Enroll ☐Change ☐Reinstate	Effective Date	Employer Name	Employer Address	
Account Number	Branch	Type of Change ☐Add Dependent ☐Cancel Employee ☐Cancel Dependent	Medical Benefit Option Code ☐ **OAP**	Dental Benefit Option ☐ **DPPO**

B			
Employee Name *(last)* *(first)* *(M.I.)*			Social Security No.
Employee Date of Birth *(MM/DD/YYYY)*	Home Phone	Work Phone	AMI Number (ID# from your Cigna Card)
Address *(Street)* *(City)* *(State)* *(Zip Code)*			

Last Name First Name M.I.	Date of Birth	Gender	Coverage Selection	ADD CANCEL	Social Security Number	Full Time Student Age 19+ Years YEARS YES NO
Employee	| |	☐ M ☐ F	☐ Medical ☐ Dental	☐ ☐		
Spouse	| |	☐ M ☐ F	☐ Medical ☐ Dental	☐ ☐		☐ ☐
Dependent	| |	☐ M ☐ F	☐ Medical ☐ Dental	☐ ☐		☐ ☐
Dependent	| |	☐ M ☐ F	☐ Medical ☐ Dental	☐ ☐		☐ ☐
Dependent	| |	☐ M ☐ F	☐ Medical ☐ Dental	☐ ☐		☐ ☐

C

Medical Benefit Options — ☐ **Open Access Plus**

Dental Benefit Options — ☐ **Dental PPO**

D

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 or Medicare No.	Effective Date	Medicare Part A	Medicare Part B	Medicaid	Insurance Carrier
			☐	☐	☐	☐

E

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

CIGNA HealthCare Provisions

- "CIGNA HealthCare" refers to various operating subsidiaries of CIGNA Corporation. Products and services provided by these subsidiaries and not by CIGNA Corporation. These subsidiaries include Connecticut General Life Insurance Company, Tel-Drug, Inc. and its affiliates, CIGNA Behavioral Health, Inc., Intracorp, and HMO or service company subsidiaries of CIGNA Health Corporation and CIGNA Dental Health, Inc.
- I agree, for myself and my 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 to fully inform the healthplan and will execute such assignments, liens or other documents which may be necessary to enable the healthplan to recover the value of the services provided. I further agree that in the event I or any of my dependents collect benefits or damages from any other party who has primary responsibility for services provided by the healthplans I will immediately reimburse the healthplan to the extent of services provided 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 PROVISION FOR EMPLOYERS WITH SECTION 125 PLANS

By allowing an individual to enroll in the Insurance Plan other than during the open enrollment period, CIGNA HealthCare or Connecticut General Life Insurance Company does not waive any terms of its contract. Further, by allowing an individual to enroll in the Insurance Plan other than during the open enrollment period, CIGNA HealthCare or Connecticut General Life Insurance Company does 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.