Medical

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

Insured and/or Administered by Cigna Health and Life Insurance Company, or its affiliates

Cigna.

Enrollment/Change Form

A ☐ OPEN ENROLL ☐ CHANGE ☐ NEW ENROLL ☐ REINSTATE | EFFECTIVE DATE OF CHANGE ADD/CHANGE/CANCELLATION (MM/DD/CCYY) / / | EMPLOYER NAME | DATE OF HIRE (MM/DD/CCYY) / / | PLAN NUMBER 00622912 | SUBGROUP | CLASS

B ☐ SINGLE ☐ MARRIED ___/___/___ ☐ SEPARATED ☐ DIVORCED ☐ WIDOWED | TYPE OF CHANGE ☐ Add Dependent(s) * ☐ Demographics ☐ PCP Change ☐ Retirement * List Name(s) in Section C ☐ COBRA Continuation Qualifying Event Date:__/__/__ ☐ Other________

C

EMPLOYEE NAME *(Last)* | *(First)* | SOCIAL SECURITY NUMBER - -

EMPLOYEE DATE OF BIRTH (MM/DD/CCYY) / / | HOME PHONE ( ) | EMAIL ADDRESS

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

☐ YES, I WOULD LIKE COVERAGE FOR MYSELF AND MY DEPENDENTS. (Specify last name if different from yours) Last Name First Name	DEPENDENT SOCIAL SECURITY NUMBER	DATE OF BIRTH (MM/DD/CCYY)	GEN-DER	COVERAGE SELECTION	Full-Time Student? Yes No	Please list PCP below (optional)	Dental Late Entrant? Yes No	If you choose the Cigna Dental Care Option: Enter your 1st and 2nd choice of Dental Office Number below.	Existing Patient? Yes No	Check One
Employee	- -	/ /	☐M ☐F	☐Medical ☐Dental ☐Vision	☐ ☐		☐ ☐	1st Choice - 2nd Choice -	☐ ☐	☐Add ☐Cancel
Dependent* Relationship	- -	/ /	☐M ☐F	☐Medical ☐Dental ☐Vision	☐ ☐		☐ ☐	1st Choice - 2nd Choice -	☐ ☐	☐Add ☐Cancel
Dependent* Relationship	- -	/ /	☐M ☐F	☐Medical ☐Dental ☐Vision	☐ ☐		☐ ☐	1st Choice - 2nd Choice -	☐ ☐	☐Add ☐Cancel
Dependent* Relationship	- -	/ /	☐M ☐F	☐Medical ☐Dental ☐Vision	☐ ☐		☐ ☐	1st Choice - 2nd Choice -	☐ ☐	☐Add ☐Cancel
Dependent* Relationship	- -	/ /	☐M ☐F	☐Medical ☐Dental ☐Vision	☐ ☐		☐ ☐	1st Choice - 2nd Choice -	☐ ☐	☐Add ☐Cancel

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

D MEDICAL OPTIONS:

- ☐ Consumer Advantage®
- ☐ PPO
- ☐ HRA
- ☐ HSA (with Banking)
- ☐ HSA (without Banking)
- ☐ Open Access Plus
- ☐ Indemnity
- ☐ LocalPlus®
- ☐ LocalPlus IN
- ☐ Cigna Care Network®
- ☐ Decline Coverage

E DENTAL OPTIONS:

- ☐ Cigna Traditional
- ☐ Cigna Dental PPO
- ☐ Cigna Dental Care® DHMO
- ☐ Cigna Dental EPO
- ☐ Decline Coverage

VISION OPTIONS:

- ☐ Cigna Vision
- ☐ Decline Coverage

F FLEXIBLE SPENDING ACCOUNT OPTIONS:

- ☐ Healthcare **
- ☐ Dependent Care **
- ☐ Decline Coverage

** If you have elected one of the Flexible Spending Accounts in this section, please complete the corresponding enrollment form included in this package.

G OTHER HEALTHCARE 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 NUMBER	EFFECTIVE DATE	MEDICARE Part A	MEDICARE Part B	MEDICAID	OTHER INSURANCE CARRIER
	- -	/ /	☐	☐	☐	
	- -	/ /	☐	☐	☐	

H 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. By my signature below, I acknowledge that I have read and understand the disclosure in this Enrollment/Change Form. I authorize the required payroll deduction for contributory benefits. I also represent that all information shown on this Enrollment/Change Form is correct. I understand that I will not be individually denied coverage or be individually charged different rates as a result of my answers. However, if I knowingly provide false information on this questionnaire, I understand and agree that it may affect the payment of claims or result in termination of my/or my dependent(s) coverage.

EMPLOYEE SIGNATURE / DATE