Enrollment / Change Form (Consolidated)
Employer: Complete Section A
Employee: Complete Section B-F

MEDICAL INSURANCE

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

A.

❑ OPEN ENROLL. ❑ CHANGE
❑ NEW ENROLL. ❑ REINSTATE

EFFECTIVE DATE (MM/DD/CCYY)	EMPLOYER NAME	EMPLOYER ADDRESS

CIGNA ACCOUNT NUMBER	DIVISION/BRANCH/ LOCATION/CLASS	DATE OF HIRE (MM/DD/CCYY)	NETWORK ID	BRANCH CODE	CDH GROUP NO.	MEDICAL BEN. OPTION	DENTAL BEN. OPTION
3212040							

TYPE OF CHANGE

❑ **Add Dependent(s)***
❑ Birth ❑ Marriage ❑ Other
❑ Adoption Placement
Date: ________________
***List Names in Section B**

❑ **Cancel Employee**
❑ Termination of Employment
❑ Other Insurance
❑ Other ________________________
Last Date Of Coverage: ______________________

❑ **Cancel Dependent(s)***
❑ Marriage ❑ Divorce
❑ Change in Student Status
❑ Other ________________________
Last Date Of Coverage: ______________________

❑ **Address Change**
❑ Transfer to COBRA
❑ 18 mos.
❑ 29 mos.
❑ 36 mos.

❑ **Family Security Benefit/ Surviving Spouse**
❑ Retirement
❑ Other ________________________

B.

EMPLOYEE NAME *(Last)*	*(First)*	*(M.I.)*	SOCIAL SECURITY NO.

HOME PHONE	WORK PHONE	HOME E-MAIL ADDRESS

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	If you choose a Managed Care Medical Option: Select your choice of Primary Care Physician (PCP) or HealthCare Center (HCC) and enter the ID Numbers below.	EXISTING PATIENT? Y	N
Employee			❑ M ❑ F	PCP or HCC Choice	❑	❑
Spouse			❑ M ❑ F	PCP or HCC Choice	❑	❑
Dependent* Relationship			❑ M ❑ F	PCP or HCC Choice	❑	❑
Dependent* Relationship			❑ M ❑ F	PCP or HCC Choice	❑	❑
Dependent* Relationship			❑ M ❑ F	PCP or HCC Choice	❑	❑

Dependents: **Marriage & Birth Certificates required for all new dependents. Relationship: Please specify (Child, Grandchild, Stepchild, etc.)**

C.

MANAGED CARE MEDICAL OPTIONS:
❑ Point-of-Service (POS)
❑ HMO/Network (or EPP)

OTHER MEDICAL OPTIONS:
❑ Preferred Provider Option (PPO)
❑ ________________________

❑ Decline Coverage

If you choose a Managed Care Medical Option, print the name of the CIGNA HealthCare Network. (See the cover or first page of the physician guide.) Include the name of the city and state.

CIGNA HealthCare of (city/ state):

D.

DENTAL OPTIONS:
❑ CIGNA Dental Care (CDC)
❑ CIGNA Dental Access (CDA)
❑ Dental PPO
❑ Dental Indemnity
❑ Decline Coverage

E.

OTHER HEALTH CARE COVERAGE:

Do you or your dependents have other health insurance under a group plan, HMO, or Medicare? ❑ No ❑ Yes *If yes, please provide the following:*

NAME OF PERSON COVERED	SOCIAL SECURITY NO.	EFFECTIVE DATE	MEDICARE Part A	MEDICARE Part B	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	SPOUSE'S SIGNATURE / DATE	EMPLOYER'S SIGNATURE / DATE

PROVISIONS

- "CIGNA HealthCare" refers to various operating subsidiaries of CIGNA Corporation. Products and services are 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 healthplan, 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 injure, defraud, or deceive any insurer, files a statement of claim or an application containing any false, incomplete or misleading information, is guilty of a felony of the third degree.

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 an 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.