

Enrollment / Change Form (Consolidated)

Employer: Complete Section A
Employee: Complete Sections B-G

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



Please print and thank you for providing this information

A	<input type="checkbox"/> OPEN ENROLL. <input type="checkbox"/> CHANGE <input type="checkbox"/> NEW ENROLL. <input type="checkbox"/> 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	CIGNA CHOICE FUND ANNUAL AMOUNT
TYPE OF CHANGE: <input type="checkbox"/> Add Dependent(s) * Date: _____ <input type="checkbox"/> Cancel Employee Last Date of Coverage: _____ <input type="checkbox"/> Cancel Dependent(s) * Last Date of Coverage: _____ * List Names in Section B										
<input type="checkbox"/> Address Change <input type="checkbox"/> Family Security Benefit/Surviving Spouse <input type="checkbox"/> Transfer to COBRA <input type="checkbox"/> Retirement <input type="checkbox"/> 18 mos. <input type="checkbox"/> 29 mos. <input type="checkbox"/> 36 mos. <input type="checkbox"/> Other _____										

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) _____						
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 <input type="checkbox"/> M <input type="checkbox"/> F	COVERAGE SELECTION <input type="checkbox"/> Medical <input type="checkbox"/> Dental	FULL TIME STUDENT? * Yes No	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. Note: PCP selection is optional for Open Access Plans.	EXISTING PATIENT? 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) <input type="checkbox"/> Add <input type="checkbox"/> Cancel
Employee							PCP or HCC Choice -	<input type="checkbox"/> <input type="checkbox"/>	1st Choice - 2nd Choice -	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> Add <input type="checkbox"/> Cancel
Spouse							PCP or HCC Choice -	<input type="checkbox"/> <input type="checkbox"/>	1st Choice - 2nd Choice -	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> Add <input type="checkbox"/> Cancel
Dependent *		Relationship				<input type="checkbox"/> <input type="checkbox"/>	PCP or HCC Choice -	<input type="checkbox"/> <input type="checkbox"/>	1st Choice - 2nd Choice -	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> Add <input type="checkbox"/> Cancel
Dependent *		Relationship				<input type="checkbox"/> <input type="checkbox"/>	PCP or HCC Choice -	<input type="checkbox"/> <input type="checkbox"/>	1st Choice - 2nd Choice -	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> Add <input type="checkbox"/> Cancel
Dependent *		Relationship				<input type="checkbox"/> <input type="checkbox"/>	PCP or HCC Choice -	<input type="checkbox"/> <input type="checkbox"/>	1st Choice - 2nd Choice -	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> Add <input type="checkbox"/> Cancel
*DEPENDENTS - If full time student and age 19 or over, attach proof verifying credit hours. If totally disabled prior to age 19, attach proof of disability for eligibility review.											

C MANAGED CARE MEDICAL OPTIONS: <input type="checkbox"/> Point-of-Service (or DPP or CHA) <input type="checkbox"/> HMO <input type="checkbox"/> Network (or EPP) <input type="checkbox"/> Point-of-Service Open Access <input type="checkbox"/> HMO Open Access <input type="checkbox"/> Network Open Access <input type="checkbox"/> Open Access Plus <input type="checkbox"/> Open Access Plus In-Network	OTHER MEDICAL OPTIONS: <input type="checkbox"/> Preferred Provider Option (PPO) <input type="checkbox"/> In-Network PPO or EPO <input type="checkbox"/> Preferred Provider Access (PPA) <input type="checkbox"/> Medical Indemnity	CIGNA CHOICE FUNDSM OPTIONS: <input type="checkbox"/> HRA <input type="checkbox"/> with PPO <input type="checkbox"/> HSA <input type="checkbox"/> with Open Access Plus <input type="checkbox"/> Pharmacy HRA <input type="checkbox"/> with Open Access Plus In-Network <input type="checkbox"/> Dental HRA <input type="checkbox"/> with EPO <input type="checkbox"/> <input type="checkbox"/> with Indemnity	<input type="checkbox"/> CIGNA Care Network <input type="checkbox"/> Decline Coverage OPTION # (if applicable): <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3
If you choose a Managed Care Medical Option other than Open Access Plus, print the name of the CIGNA HealthCare network. (See the cover or first page of the physician directory). Include the name of the city and state.		CIGNA HealthCare of (city/state): _____	

D FLEXIBLE SPENDING ACCOUNT OPTIONS: <input type="checkbox"/> Health Care* <input type="checkbox"/> Dependent Day Care* <input type="checkbox"/> Decline Coverage	E DENTAL OPTIONS: <input type="checkbox"/> CIGNA Dental Care (CDC) <input type="checkbox"/> Dental PPO <input type="checkbox"/> Dental EPO <input type="checkbox"/> Dental Indemnity <input type="checkbox"/> Decline Coverage
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*If you have checked off one of the Flexible Spending Accounts in Section D, please make sure you have completed the corresponding enrollment form included in this package.

F OTHER HEALTH CARE COVERAGE: Do you or your dependents have other health insurance under a group plan, HMO, or Medicare? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please provide the following:							
NAME OF PERSON COVERED	SOCIAL SECURITY NO.	EFFECTIVE DATE	MEDI- CARE Part A	Part B	MEDI- CAID	OTHER INSUR- ANCE CARRIER	
_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

G 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
_____	_____	_____

**IMPORTANT! BEFORE YOU WRITE ON THIS SIDE:
DETACH THIS PAGE BEFORE COMPLETING SECTIONS H AND I**

Employee: Complete Sections H-I if applicable

H	LIFE AND AD&D	EMPLOYEE	DEPENDENT	STD AND LTD	EMPLOYEE
	<input type="checkbox"/> Life <input type="checkbox"/> Additional Life <input type="checkbox"/> Dependent Life - Spouse <input type="checkbox"/> Dependent Life - Child(ren) <input type="checkbox"/> Accidental Death & Dismemberment (AD&D) <input type="checkbox"/> Additional AD&D	\$ \$ \$ \$ \$	\$ \$ \$	<input type="checkbox"/> Short Term Disability (STD) <input type="checkbox"/> Long Term Disability (LTD)	\$ \$

I	IF YOU ELECT LIFE OR AD&D BENEFITS, INDICATE YOUR BENEFICIARY BELOW.				
	BENEFICIARY NAME (Last)	(First)	(M.I.)	RELATIONSHIP	% OF INSURANCE

IMPORTANT: If you have chosen medical coverage and your employer is providing Life and/or AD&D coverage, please forward a copy of this page, along with the first ply of this form as your employer directs.

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 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 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.