Enrollment / Change Form (Consolidated)

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

Insured and/or Administered by
Cigna Health and Life Insurance Company
Cigna HealthCare

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.	MEDICAL BEN. OPTION	DENTAL BEN. OPTION	VISION BEN. OPTION	CIGNA CHOICE FUND ANNUAL AMOUNT

TYPE OF CHANGE:

☐ **Add Dependent(s) *** Date: ____
☐ **Cancel Employee** Last Date of Coverage: ____
☐ **Cancel Dependent(s) *** Last Date of Coverage: ____
☐ **Address Change**
☐ **Transfer to COBRA** ☐ 18 mos. ☐ 29 mos. ☐ 36 mos.
☐ **Family Security Benefit/Surviving Spouse**
☐ **Retirement**
☐ **Other** ____

*** List Names in Section B**

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
	( )	( )		

MAILING 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	COVERAGE SELECTION	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)*
Employee		| |	☐ M ☐ F	☐ Med. ☐ Vis. ☐ Dent.		PCP or HCC Choice -	☐ ☐	1st Choice - / 2nd Choice -	☐ ☐ / ☐ ☐	☐ Add / ☐ Cancel
Spouse		| |	☐ M ☐ F	☐ Med. ☐ Vis. ☐ Dent.		PCP or HCC Choice -	☐ ☐	1st Choice - / 2nd Choice -	☐ ☐ / ☐ ☐	☐ Add / ☐ Cancel
Dependent * Relationship		| |	☐ M ☐ F	☐ Med. ☐ Vis. ☐ Dent.	☐ ☐	PCP or HCC Choice -	☐ ☐	1st Choice - / 2nd Choice -	☐ ☐ / ☐ ☐	☐ Add / ☐ Cancel
Dependent * Relationship		| |	☐ M ☐ F	☐ Med. ☐ Vis. ☐ Dent.	☐ ☐	PCP or HCC Choice -	☐ ☐	1st Choice - / 2nd Choice -	☐ ☐ / ☐ ☐	☐ Add / ☐ Cancel
Dependent * Relationship		| |	☐ M ☐ F	☐ Med. ☐ Vis. ☐ Dent.	☐ ☐	PCP or HCC Choice -	☐ ☐	1st Choice - / 2nd Choice -	☐ ☐ / ☐ ☐	☐ Add / ☐ Cancel

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

C

MANAGED CARE MEDICAL OPTIONS:
☐ Point-of-Service (or DPP or CHA)
☐ HMO
☐ Network (or EPP)
☐ Point-of-Service Open Access
☐ HMO Open Access
☐ Network Open Access
☐ Open Access Plus
☐ Open Access Plus In-Network

OTHER MEDICAL OPTIONS:
☐ Preferred Provider Option (PPO)
☐ In-Network PPO or EPO
☐ Preferred Provider Access (PPA)
☐ Medical Indemnity
☐ ____

CIGNA CHOICE FUND® OPTIONS:
☐ HRA
☐ HSA
☐ Pharmacy HRA
☐ Dental HRA
☐ with PPO
☐ with Open Access Plus
☐ with Open Access Plus In-Network
☐ with EPO
☐ with Indemnity

☐ Cigna Care Network®
☐ Decline Coverage

OPTION # ***(if applicable):*** ☐ 1 ☐ 2 ☐ 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:
☐ Health Care*
☐ Dependent Day Care*
☐ Decline Coverage

E

DENTAL OPTIONS:
☐ DHMO (Cigna Dental Care®)
☐ Dental PPO
☐ Dental EPO
☐ Dental Indemnity
☐ Decline Coverage

F

VISION OPTIONS:
☐ Cigna Vision
☐ Decline Coverage

*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.

G

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 NO.	EFFECTIVE DATE	MEDICARE Part A	MEDICARE Part B	MEDICARE ID #	MEDICAID	OTHER INSURANCE CARRIER
			☐	☐		☐	☐
			☐	☐		☐	☐

H

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