

Enrollment / Change Form (Consolidated)

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



Please print and thank you for providing this information

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

A

<input type="checkbox"/> OPEN ENROLL. <input type="checkbox"/> NEW ENROLL.	<input type="checkbox"/> CHANGE REINSTATE	EFFECTIVE DATE (MM/DD/CCYY)	EMPLOYER NAME	EMPLOYER ADDRESS
CIGNA ACCOUNT NO.	DIVISION/BRANCH/LOCATION/CLASS	DATE OF HIRE (MM/DD/CCYY)	NETWORK ID	CDH GROUP NO.
MEDICAL BEN. OPTION	DENTAL BEN. OPTION	HEALTH SAVINGS ACCOUNT ANNUAL AMOUNT	TYPE OF CHANGE:	
<input type="checkbox"/> Add Dependent(s) *		<input type="checkbox"/> Address Change		
<input type="checkbox"/> Birth		<input type="checkbox"/> Marriage		
<input type="checkbox"/> Adoption Placement		<input type="checkbox"/> Divorce		
Date:		<input type="checkbox"/> Transfer to COBRA		
Last Date of Coverage:		<input type="checkbox"/> 18 mos.		
* List Names in Section B		<input type="checkbox"/> 29 mos.		
		<input type="checkbox"/> 36 mos.		
		SOCIAL SECURITY NO.		

B

EMPLOYEE NAME (Last)	(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)	DEPENDENT SOCIAL SECURITY NO.	DATE OF BIRTH MM DD CCYY	GENDER	COVERAGE SELECTION	FULL TIME STUDENT? Yes No	If you choose a Managed Care Medical Option: Select your choice of Primary Care Physician (PCP) or Health Care Network. PCP selection is not required for Open Access Plans.	EXISTING PATIENT? Yes No	If you choose the CIGNA Dental Access Option: Enter your 1st and 2nd choice of Dental Office Number below.	EXISTING PATIENT? Yes No
Employee			M			PCP or HCC Choice -		1st Choice -	
Spouse			F			PCP or HCC Choice -		2nd Choice -	
Dependent *			M			PCP or HCC Choice -		1st Choice -	
Dependent *			F			PCP or HCC Choice -		2nd Choice -	
Dependent *			M			PCP or HCC Choice -		1st Choice -	
Dependent *			F			PCP or HCC Choice -		2nd Choice -	

* 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:

Point-of-Service (or PPO or CHA)
 Network Open Access
 HSA PPO
 HSA PPO

HMO
 In-Network PPO or EPO
 HSA EPO
 HSA EPO

Network (or EPP)
 HSA Network Open Access
 HSA Indemnity

Point-of-Service Open Access
 Preferred Provider Access (PPA)

HMO Open Access
 Medical Indemnity

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):

OTHER MEDICAL OPTIONS:

Decline Coverage
 Preferred Provider Option (PPO)
 HSA PPO

Flexible Spending Account (FSA)
 In-Network PPO or EPO
 HSA EPO

Health Care
 HSA Indemnity

Dependent Day Care
 Commuter

Decline Coverage

DENTAL OPTIONS:

CIGNA Dental Care (CDC)

F

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:

MEDICARE Part A Part B MEDICAID OTHER INSURANCE CARRIER

SOCIAL SECURITY NO.

EFFECTIVE DATE

EMPLOYEE'S SIGNATURE / DATE

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