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

Insured and/or Administered by Cigna Health and Life Insurance Company
Cigna Dental Health of Ohio, Inc.

Cigna

Enrollment/Change Form

A		EFFECTIVE DATE OF CHANGE ADD/CHANGE/ CANCELLATION (MM/DD/CCYY)	EMPLOYER NAME	DATE OF HIRE (MM/DD/CCYY)	PLAN NUMBER	SUB-GROUP	CLASS
	☐ OPEN ENROLL ☐ CHANGE ☐ NEW ENROLL ☐ REINSTATE	_____/_____/_____		_____/_____/_____			

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	Depen-dent Social Security Number	Date of Birth (MM/DD/ CCYY)	GENDER	Coverage Selection	Full-Time Student? Yes No	Please list PCP below (opt-ional)	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 _____
- ☐ Cigna Care Network® _____
- ☐ Decline Coverage

E

DENTAL OPTIONS:	VISION OPTIONS:
☐ Cigna Traditional _____	☐ Cigna Vision
☐ Cigna Dental PPO _____	☐ Decline Coverage
☐ Cigna Dental EPO _____	
☐ Cigna Dental Care® DHMO _____	
☐ 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	MEDICARE / MEDICAID	OTHER INSURANCE SOCIAL SECURITY NUMBER / CARRIER	EFFECTIVE DATE	Part A	Part B
		- -	_____/_____/_____	☐	☐
		- -	_____/_____/_____	☐	☐

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.

EMPLOYEE SIGNATURE / DATE

PROVISIONS

- In Ohio, the Cigna Dental Care (DHMO) plan is underwritten by Cigna Dental Health of Ohio, Inc. and administered by Cigna Dental Health, Inc.
- The Cigna Dental PPO and Traditional plans are underwritten or administered by Cigna Health and Life Insurance Company, with network management services provided by Cigna Dental Health, Inc.
- I agree, for myself and my covered 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, I will fully inform the health plan and will execute such assignments, liens or other documents which may be necessary to enable the health plan to recover the value of the services provided. I further agree that in the event I or any of my covered dependents collect benefits or damages from any other party who has primary responsibility for services provided by the health plan, I will immediately reimburse the health plan 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 PROVISIONS FOR EMPLOYERS WITH SECTION 125 PLANS

By allowing an individual to enroll in the health plan, other than during the open enrollment period, Cigna Health and Life Insurance Company and its affiliates do not waive any terms of its contract. Further, by allowing an individual to enroll in the health plan, other than during an open enrollment period, Cigna Health and Life Insurance Company and its affiliates do 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.

SPECIAL STATE PROVISION

Cancellation Notice: (1) any person obligated for any part of a pre-payment may cancel such agreement within 72 hours after having signed the agreement or offer to enroll; (2) cancellation occurs when written notice of cancellation is given to the Health Insuring Corporation (HIC) or its agents or other representatives; (3) Notice of Cancellation shall be considered given the prospective subscriber mails a letter to the HIC.