

Enrollment / Change Form (Consolidated)

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



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

Please print and thank you for providing this information

<input type="checkbox"/> OPEN ENROLL <input type="checkbox"/> CHANGE <input type="checkbox"/> NEW ENROLL <input type="checkbox"/> REINSTATE		EMPLOYER ADDRESS	
CIGNA ACCOUNT NO.	DIVISION/BRANCH/LOCATION/CLASS	DATE OF HIRE (MM/DD/CCYY)	EMPLOYER NAME
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: _____
 * List Names in Section B

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

Family Security Benefits/ Surviving Spouse
 Retirement
 Other

EMPLOYEE NAME (Last)	(First)	(M.I.)	SOCIAL SECURITY NO.
EMPLOYEE DATE OF BIRTH (MM/DD/CCYY)	HOME PHONE () ()	WORK PHONE () ()	EMPLOYEE IDENTIFICATION NUMBER
Mailing Address	(City)	(State)	(Zip Code)

I WOULD LIKE COVERAGE FOR ME AND MY DEPENDENTS. (Specify first 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. Dent. Vis.		PCP or HCC Choice -				Add Cancel
Spouse						M F	Med. Dent. Vis.		PCP or HCC Choice -				Add Cancel
Dependent *						M F	Med. Dent. Vis.		PCP or HCC Choice -				Add Cancel
Dependent *						M F	Med. Dent. Vis.		PCP or HCC Choice -				Add Cancel
Dependent *						M F	Med. Dent. Vis.		PCP or HCC 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.

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	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 FUND OPTIONS: <input type="checkbox"/> HRA <input type="checkbox"/> HSA <input type="checkbox"/> Pharmacy HRA <input type="checkbox"/> Dental HRA	CIGNA CARE NETWORK: <input type="checkbox"/> Network <input type="checkbox"/> Decline Coverage <input type="checkbox"/> with Open Access Plus <input type="checkbox"/> with Open Access Plus In-Network <input type="checkbox"/> with EPO <input type="checkbox"/> with Indemnity	CIGNA HealthCare of (city/state)
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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).

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

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 _____
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