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

Enrollment / Change Form (Consolidated)

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

PLEASE PRINT CLEARLY AND ONLY LIST DEPENDENTS TO BE ENROLLED IN CIGNA MEDICAL COVERAGE

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: ____________ ☐ Address Change ☐ Family Security Benefit/Surviving Spouse
☐ Cancel Employee Last Date of Coverage: ____________ ☐ Transfer to COBRA ☐ Retirement
☐ Cancel Dependent(s) * Last Date of Coverage: ____________ ☐ 18 mos. ☐ 29 mos. ☐ 36 mos. ☐ 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	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 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	Medical Only		PCP or HCC Choice -	☐ ☐	1st Choice - / 2nd Choice	☐ ☐ / ☐ ☐	☐ Add ☐ Cancel
Spouse			☐ M ☐ F	Medical Only		PCP or HCC Choice -	☐ ☐	1st Choice - / 2nd Choice	☐ ☐ / ☐ ☐	☐ Add ☐ Cancel
Dependent * Relationship			☐ M ☐ F	Medical Only	☐ ☐	PCP or HCC Choice -	☐ ☐	1st Choice - / 2nd Choice	☐ ☐ / ☐ ☐	☐ Add ☐ Cancel
Dependent * Relationship			☐ M ☐ F	Medical Only	☐ ☐	PCP or HCC Choice -	☐ ☐	1st Choice - / 2nd Choice	☐ ☐ / ☐ ☐	☐ Add ☐ Cancel
Dependent * Relationship			☐ M ☐ F	Medical Only	☐ ☐	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:

☐ **Open Access Plus**
☐ **Open Access Basic**

☐ **WAIVED 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.

D

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
			☐	☐		☐	☐
			☐	☐		☐	☐

E

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