Enrollment / Change Form (Consolidated)

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

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

Please print and thank you for providing this information

A

☐ OPEN ENROLL. ☐ CHANGE
☐ NEW ENROLL. ☐ REINSTATE

EFFECTIVE DATE (MM/DD/CCYY)	EMPLOYER NAME	CIGNA ACCOUNT NO.	DIVISION / BRANCH / LOCATION / CLASS	DATE OF HIRE (MM/DD/CCYY)	NETWORK ID / HMO CODE
				GROUP / DIV. NO.	CDH GROUP NO.
				MEDICAL BEN. OPTION	DENTAL BEN. OPTION

TYPE OF CHANGE:
- ☐ Add Dependent(s) *
  - ☐ Birth ☐ Marriage
  - ☐ Adoption Placement
  - ☐ Other
  - Date: _____
- ☐ Cancel Employee
  - ☐ Termination of Employment
  - ☐ Other Insurance
  - ☐ Other _____
- ☐ Address Change
- ☐ Cancel Dependent(s) *
  - ☐ Marriage ☐ Divorce
  - ☐ Change in Student Status
  - ☐ Other _____
- ☐ 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.	HOME PHONE ( )	WORK PHONE ( )

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.	DATE OF BIRTH MM DD CCYY	SEX	COVERAGE SELECTION Medical	Dental	FULL TIME STUDENT? * Yes	No	If you choose a Managed Care Medical Option: Select your 1st and 2nd choice of Primary Care Physician (PCP) or HealthCare Center (HCC) and enter the ID Numbers below.	EXISTING PATIENT? Yes	No	If you choose the CIGNA Dental Care or CIGNA Dental Access Option: Enter your 1st and 2nd choice of Dental Office Number below.	EXISTING PATIENT? Yes	No
Employee		☐ M ☐ F	☐	☐			1st Choice -	☐	☐	1st Choice -	☐	☐
							2nd Choice -	☐	☐	2nd Choice -	☐	☐
Spouse		☐ M ☐ F	☐	☐			1st Choice -	☐	☐	1st Choice -	☐	☐
							2nd Choice -	☐	☐	2nd Choice -	☐	☐
Dependent * Relationship		☐ M ☐ F	☐	☐	☐	☐	1st Choice -	☐	☐	1st Choice -	☐	☐
							2nd Choice -	☐	☐	2nd Choice -	☐	☐
Dependent * Relationship		☐ M ☐ F	☐	☐	☐	☐	1st Choice -	☐	☐	1st Choice -	☐	☐
							2nd Choice -	☐	☐	2nd Choice -	☐	☐
Dependent * Relationship		☐ M ☐ F	☐	☐	☐	☐	1st Choice -	☐	☐	1st Choice -	☐	☐
							2nd 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:
- ☐ FlexCare Point of Service (DPP)
- ☐ FlexCare (EPP)
- ☐ Point of Service (CHA)
- ☐ HMO (CHC)

OTHER MEDICAL OPTIONS:
- ☐ Preferred Provider Option (PPO)
- ☐ Preferred Provider Access (PPA)
- ☐ Medical Indemnity
- ☐ _____
- ☐ Decline Coverage

OPTION # *(if applicable):*
- ☐ 1
- ☐ 2
- ☐ 3

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):

D

DENTAL OPTIONS:
- ☐ CIGNA Dental Care (CDC)
- ☐ CIGNA Dental Access (CDA)
- ☐ Dental PPO
- ☐ Dental Indemnity
- ☐ Decline Coverage

E

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.	EMPLOYER	INSURANCE COMPANY NAME AND ADDRESS	MEDICARE Part A	Part B
				☐	☐
				☐	☐

Have you or your dependent(s) ever been covered by a CIGNA HealthCare Network?
☐ Yes ☐ No
If yes, Name of Person Covered _____
Social Security No. _____ Covered As: ☐ Employee ☐ Dependent
Name of Healthplan: CIGNA HealthCare of: _____ *(city / state)*

F

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

DISTRIBUTION: **Original:** CIGNA HealthCare / Eligibility Services **2nd Ply:** CIGNA Eligibility Services / CDH / Dental Claim Office **3rd Ply:** Employee **4th Ply:** Employer