

Enrollment / Change Form (Consolidated)

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

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



Please print and thank you for providing this information

A	<input type="checkbox"/> OPEN ENROLL. <input type="checkbox"/> CHANGE <input type="checkbox"/> NEW ENROLL. <input type="checkbox"/> 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	BRANCH CODE	CDH GROUP NO.	MEDICAL BEN. OPTION	DENTAL BEN. OPTION				
TYPE OF CHANGE: <input type="checkbox"/> Add Dependent(s) * <input type="checkbox"/> Birth <input type="checkbox"/> Marriage <input type="checkbox"/> Other <input type="checkbox"/> Adoption Placement Date: _____								<input type="checkbox"/> Cancel Employee <input type="checkbox"/> Termination of Employment <input type="checkbox"/> Other Insurance <input type="checkbox"/> Other _____ Last Date of Coverage: _____	<input type="checkbox"/> Cancel Dependent(s) * <input type="checkbox"/> Marriage <input type="checkbox"/> Divorce <input type="checkbox"/> Change in Student Status <input type="checkbox"/> Other _____ Last Date of Coverage: _____	<input type="checkbox"/> Address Change <input type="checkbox"/> Transfer to COBRA <input type="checkbox"/> 18 mos. <input type="checkbox"/> 29 mos. <input type="checkbox"/> 36 mos.	<input type="checkbox"/> Family Security Benefit / Surviving Spouse <input type="checkbox"/> Retirement <input type="checkbox"/> Other _____
* List Names in Section B											

EMPLOYEE NAME (Last) _____ (First) _____ (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. <i>(Specify last name if different from yours)</i>		DEPENDENT SOCIAL SECURITY NO.	DATE OF BIRTH		GENDER	COVERAGE SELECTION		FULL TIME STUDENT? *		<i>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.</i>		EXISTING PATIENT?		<i>If you choose the CIGNA Dental Care or CIGNA Dental Access Option: Enter your 1st and 2nd choice of Dental Office Number below.</i>		EXISTING PATIENT?	
Last Name First Name M.I.			MM DD CCYY			Medical Dental		Yes No		PCP or HCC Choice -		Yes No		1st Choice -		Yes No	
Employee					<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> <input type="checkbox"/>				PCP or HCC Choice -		<input type="checkbox"/> <input type="checkbox"/>		2nd Choice -		<input type="checkbox"/> <input type="checkbox"/>	
Spouse					<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> <input type="checkbox"/>				PCP or HCC Choice -		<input type="checkbox"/> <input type="checkbox"/>		1st Choice -		<input type="checkbox"/> <input type="checkbox"/>	
Dependent *		Relationship			<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/> <input type="checkbox"/>		PCP or HCC Choice -		<input type="checkbox"/> <input type="checkbox"/>		1st Choice -		<input type="checkbox"/> <input type="checkbox"/>	
Dependent *		Relationship			<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/> <input type="checkbox"/>		PCP or HCC Choice -		<input type="checkbox"/> <input type="checkbox"/>		1st Choice -		<input type="checkbox"/> <input type="checkbox"/>	
Dependent *		Relationship			<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/> <input type="checkbox"/>		PCP or HCC Choice -		<input type="checkbox"/> <input type="checkbox"/>		1st Choice -		<input type="checkbox"/> <input type="checkbox"/>	
					<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/> <input type="checkbox"/>		PCP or HCC Choice -		<input type="checkbox"/> <input type="checkbox"/>		2nd Choice -		<input type="checkbox"/> <input type="checkbox"/>	
* 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: <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 <input type="checkbox"/> HMO Open Access <input type="checkbox"/> Network 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 <input type="checkbox"/> _____	<input type="checkbox"/> Decline Coverage OPTION # (if applicable): <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3	<i>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.</i> CIGNA HealthCare of (city / state): _____	D	DENTAL OPTIONS: <input type="checkbox"/> CIGNA Dental Care (CDC) <input type="checkbox"/> CIGNA Dental Access (CDA) <input type="checkbox"/> Dental PPO <input type="checkbox"/> Dental Indemnity <input type="checkbox"/> Decline Coverage
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E	OTHER HEALTH CARE COVERAGE: Do you or your dependents have other health insurance under a group plan, HMO, or Medicare? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If yes, please provide the following:</i>							
	NAME OF PERSON COVERED	SOCIAL SECURITY NO.	EFFECTIVE DATE	MEDICARE Part A	MEDICARE Part B	MEDICAID	OTHER INSURANCE CARRIER	
	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

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
	_____	_____	_____

**IMPORTANT! BEFORE YOU WRITE ON THIS SIDE:
DETACH THIS PAGE BEFORE COMPLETING SECTIONS G AND H**

Employee: Complete Sections G-H if applicable

G	LIFE AND AD&D	EMPLOYEE	DEPENDENT	STD AND LTD	EMPLOYEE
	<input type="checkbox"/> Life <input type="checkbox"/> Additional Life <input type="checkbox"/> Dependent Life - Spouse <input type="checkbox"/> Dependent Life - Child(ren) <input type="checkbox"/> Accidental Death & Dismemberment (AD&D) <input type="checkbox"/> Additional AD&D	\$ \$ \$ \$ \$	\$ \$ \$	<input type="checkbox"/> Short Term Disability (STD) <input type="checkbox"/> Long Term Disability (LTD)	\$ \$

H	IF YOU ELECT LIFE OR AD&D BENEFITS, INDICATE YOUR BENEFICIARY BELOW.				
	BENEFICIARY NAME (Last)	(First)	(M.I.)	RELATIONSHIP	% OF INSURANCE

IMPORTANT: If you have chosen medical coverage and your employer is providing Life and/or AD&D coverage, please forward a copy of this page, along with the first ply of this form as your employer directs.

PROVISIONS

AUTHORIZATION TO DISCLOSE CONFIDENTIAL INFORMATION AND FRAUD NOTICE

- I understand that after I enroll, CIGNA HealthCare or Connecticut General Life Insurance Company may need to obtain Confidential Information. I also understand that CIGNA HealthCare or Connecticut General Life Insurance Company may need to provide this Confidential Information to others. Any person or entity having Confidential Information has my permission to provide this Confidential Information upon request to CIGNA HealthCare or Connecticut General Life Insurance Company, any CIGNA HealthCare or Connecticut General Life Insurance Company participating provider, or any other provider or entity performing a service for the purpose of plan administration, the performance of any CIGNA HealthCare or Connecticut General Life Insurance Company program or operations, or to assess the quality of and access to health care services and supplies. CIGNA HealthCare or Connecticut General Life Insurance Company has my permission to give any Confidential Information to any person, company or entity when it determines that such disclosure is necessary or appropriate for the administration of the plan, the performance of CIGNA HealthCare or Connecticut General Life Insurance Company programs or operations, assessing quality and accessibility of health care services and supplies, or reporting to third parties involved in plan administration. I am making this authorization for myself and as the agent or representative of my spouse and any dependent children. I understand that it will remain in effect until I send written notice revoking it to CIGNA HealthCare or Connecticut General Life Insurance Company or for such shorter period as required by law. Until revoked, this authorization may be relied upon by CIGNA HealthCare or Connecticut General Life Insurance Company and other parties. "Confidential Information" means, with respect to me and any covered dependents, any medical, dental, mental health, substance abuse, communicable disease, AIDS and HIV related information and disability or employment related information. CIGNA HealthCare or Connecticut General Life Insurance Company means the CIGNA companies involved in the administration of the plan.
- Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subject such person to criminal and civil penalties.

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.

APPLICABLE TO HMO BENEFITS

- CIGNA HealthCare provides HMO coverage under agreements with your employer, and provides the HMO and the in-network coverage for the Point of Service product.
- CIGNA HealthCare provides HMO services to its members and also makes its networks available to Connecticut General Life Insurance Company Flexcare enrollees.
- I agree, for myself and my 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 to fully inform the healthplan and will execute such assignments, liens or other documents which may be necessary to enable the healthplan to recover the value of the services provided. I further agree that in the event I or any of my dependents collect benefits or damages from any other party who has primary responsibility for services provided by the healthplan, I will immediately reimburse the healthplan to the extent of services provided, to the extent permitted by state law.

SPECIAL PROVISION FOR EMPLOYERS WITH SECTION 125 PLANS

- By allowing an individual to enroll in the Insurance Plan other than during the open enrollment period, CIGNA HealthCare or Connecticut General Life Insurance Company does not waive any terms of its contract. Further, by allowing an individual to enroll in the Insurance Plan other than during an open enrollment period, CIGNA HealthCare or Connecticut General Life Insurance Company does 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 PROVISIONS

- **CA Residents Only:** The Healthplan uses binding arbitration to settle disputes, including claims of medical malpractice and disputes relating to the delivery of service under the plan. It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review or arbitration proceedings. The parties to this contract, by entering into it, are giving up their constitutional right to have any dispute decided in a court of law before a jury, and instead are accepting the use of arbitration. It is understood that this agreement to arbitrate shall apply and extend to any dispute for medical malpractice, relating to the delivery of service under the plan, and to any claims in tort, contract or otherwise, between Group, any individual(s) seeking services under the plan, whether referred to as a Member, Subscriber, Dependent, Enrollee or otherwise (whether a minor or an adult), or the heirs-at-law or personal representatives of any such individual(s), as the case may be, and the Healthplan (including any of their agents, successors- or predecessors-in-interest, employees, or providers).
- **Kansas Residents Only:** I further agree that in the event I or any of my dependents collect benefits or damages from any other party who has primary responsibility for services provided by the healthplan, I will immediately reimburse the healthplan to the extent of services provided, to the extent permitted by applicable state law.
- **Mid-Atlantic:** A referral from the enrollee's Primary Care Physician is not required for routine gynecological care received from a network gynecologist, out-of-area emergency-urgent care, or out of network care received under the Point of Service option.
- **Georgia:** If you were a former patient of a designated doctor and are now considering selecting that doctor, you are considered a "new patient". I hereby apply for membership in CIGNA HealthCare of Georgia, Inc. or Connecticut General Life Insurance Company and authorize my employer/union/association to deduct any required contribution from earnings. I hereby authorize any physician, hospital, insurer or other organization or person have in any records, data or information concerning health history or medical insurance for me or my family members to furnish such records, data, or information as may be requested by CIGNA HealthCare of Georgia, Inc. or Connecticut General Life Insurance Company, or their duly authorized representative. A photocopy of this authorization shall be considered as effective and valid as the original. CIGNA HealthCare or Connecticut General Life Insurance Company must be notified of all changes. I authorize that payment be made under Part B of Medicare to CIGNA HealthCare of Georgia, Inc. or Connecticut General Life Insurance Company for medical and other services furnished me for which it pays or had paid.