

# Enrollment / Change Form (Consolidated)

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

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



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		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	CIGNA CHOICE FUND ANNUAL AMOUNT	
<b>TYPE OF CHANGE:</b> <input type="checkbox"/> Add Dependent(s) *   Date: _____ <input type="checkbox"/> Cancel Employee   Last Date of Coverage: _____ <input type="checkbox"/> Cancel Dependent(s) *   Last Date of Coverage: _____ * List Names in Section B									
<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 _____						

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					
ADDRESS (Street)		(City)			(State)		(Zip Code)				
<b>I WOULD LIKE COVERAGE FOR ME AND MY DEPENDENTS.</b> <small>(Specify last name if different from yours)</small>		DEPENDENT SOCIAL SECURITY NO.	DATE OF BIRTH	GEN- DER	COVERAGE SELECTION	FULL TIME STUDENT? *	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?	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?	(check one)
Last Name	First Name	M.I.	MM	DD	CCYY	Yes	No	Yes	No	Yes	No
Employee						<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Medical <input type="checkbox"/> Dental	PCP or HCC Choice -	<input type="checkbox"/> <input type="checkbox"/>	1st Choice - 2nd Choice -	<input type="checkbox"/> <input type="checkbox"/> Add <input type="checkbox"/> <input type="checkbox"/> Cancel
Spouse						<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Medical <input type="checkbox"/> Dental	PCP or HCC Choice -	<input type="checkbox"/> <input type="checkbox"/>	1st Choice - 2nd Choice -	<input type="checkbox"/> <input type="checkbox"/> Add <input type="checkbox"/> <input type="checkbox"/> Cancel
Dependent *	Relationship					<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Medical <input type="checkbox"/> Dental	PCP or HCC Choice -	<input type="checkbox"/> <input type="checkbox"/>	1st Choice - 2nd Choice -	<input type="checkbox"/> <input type="checkbox"/> Add <input type="checkbox"/> <input type="checkbox"/> Cancel
Dependent *	Relationship					<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Medical <input type="checkbox"/> Dental	PCP or HCC Choice -	<input type="checkbox"/> <input type="checkbox"/>	1st Choice - 2nd Choice -	<input type="checkbox"/> <input type="checkbox"/> Add <input type="checkbox"/> <input type="checkbox"/> Cancel
Dependent *	Relationship					<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Medical <input type="checkbox"/> Dental	PCP or HCC Choice -	<input type="checkbox"/> <input type="checkbox"/>	1st Choice - 2nd Choice -	<input type="checkbox"/> <input type="checkbox"/> Add <input type="checkbox"/> <input type="checkbox"/> Cancel

\* 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.

<b>C MANAGED CARE MEDICAL OPTIONS:</b> <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		<b>OTHER MEDICAL OPTIONS:</b> <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		<b>CIGNA CHOICE FUND<sup>SM</sup> OPTIONS:</b> <input type="checkbox"/> HRA <input type="checkbox"/> HSA <input type="checkbox"/> Pharmacy HRA <input type="checkbox"/> Dental HRA		<input type="checkbox"/> with PPO <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		<input type="checkbox"/> CIGNA Care Network <input type="checkbox"/> Decline Coverage <b>OPTION # (if applicable):</b> <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3		<b>D FLEXIBLE SPENDING ACCOUNT OPTIONS:</b> <input type="checkbox"/> Health Care* <input type="checkbox"/> Dependent Day Care* <input type="checkbox"/> Decline Coverage		<b>E DENTAL OPTIONS:</b> <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	
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). Include the name of the city and state.						CIGNA HealthCare of (city/state): _____							

\*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.

<b>F OTHER HEALTH CARE COVERAGE:</b> 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		OTHER INSURANCE CARRIER	
						Part A   Part B			
						<input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/> <input type="checkbox"/>	

<b>G SIGNATURE</b> - 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