



1. Your employer will complete section A.
2. Complete sections B through F.
3. If you are electing medical, complete the section entitled "MEDICAL OPTIONS."
 - You have the option of selecting a Primary Care Physician (PCP) for yourself and each covered dependent. Your PCP can provide most medical services and can assist with hospital and specialist recommendations.

If you need help selecting a PCP, contact Member Services.
4. Read the information on the back of the enrollment/change form.
5. Sign and date the enrollment/change.

We look forward to having you as our customer.

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

Insured and/or Administered by Cigna Health and Life Insurance Company, or its affiliates



Enrollment/Change Form

A	<input type="checkbox"/> OPEN ENROLL	<input type="checkbox"/> CHANGE	EFFECTIVE DATE OF CHANGE ADD/CHANGE/CANCELLATION (MM/DD/CCYY) ____/____/____	EMPLOYER NAME City of Centennial	DATE OF HIRE (MM/DD/CCYY) ____/____/____	PLAN NUMBER 610377	SUBGROUP	CLASS
	<input type="checkbox"/> NEW ENROLL	<input type="checkbox"/> REINSTATE						

B	<input type="checkbox"/> SINGLE	<input type="checkbox"/> MARRIED ____/____/____	TYPE OF CHANGE <input type="checkbox"/> Add Dependent(s) * <input type="checkbox"/> Demographics <input type="checkbox"/> PCP Change <input type="checkbox"/> Retirement
	<input type="checkbox"/> SEPARATED	<input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED	

C	EMPLOYEE NAME (Last)		(First)		SOCIAL SECURITY NUMBER					
	EMPLOYEE DATE OF BIRTH (MM/DD/CCYY) ____/____/____				HOME PHONE (____) _____		EMAIL ADDRESS			
	ADDRESS (Street) _____					(City) _____		(State) _____	(Zip Code) _____	
	<input type="checkbox"/> YES, I WOULD LIKE COVERAGE FOR MYSELF AND MY DEPENDENTS. (Specify last name if different from yours)		Dependent Social Security Number	Date of Birth (MM/DD/CCYY)	Gender	H e i g h t	W e i g h t	Coverage Selection	Full-Time Student?	Please list PCP below (optional)
	Employee Last Name First Name		- -	/ /	<input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/> Med	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Dependent Relationship		- -	/ /	<input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/> Med	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Dependent Relationship		- -	/ /	<input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/> Med	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Dependent Relationship		- -	/ /	<input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/> Med	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Dependent Relationship		- -	/ /	<input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/> Med	<input type="checkbox"/> Yes <input type="checkbox"/> No		

ADDITIONAL INFORMATION. * DEPENDENTS – If totally disabled prior to age 26, attach proof of disability for eligibility review. Dependents are covered under the medical plan to age 26. Proof of student status may be required for dental and/or vision coverage.

D	MEDICAL OPTIONS:	
	<input type="checkbox"/>	LocalPlus IN@/ _____
	<input type="checkbox"/>	Open Access Plus/ _____
	<input type="checkbox"/>	
	<input type="checkbox"/>	Decline Coverage

E	OTHER HEALTHCARE 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		If yes, please provide the following:				
	NAME OF PERSON COVERED	SOCIAL SECURITY NUMBER	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"/>		

F

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. By my signature below, I acknowledge that I have read and understand the disclosure in this Enrollment/Change Form. I authorize the required payroll deduction for contributory benefits. I also represent that all information shown on this Enrollment/Change Form is correct. I understand that I will not be individually denied coverage or be individually charged different rates as a result of my answers. However, if I knowingly provide false information on this Questionnaire, I understand and agree that it may affect the payment of claims or result in termination of my/or my dependent(s) coverage.

EMPLOYEE SIGNATURE / DATE

PROVISIONS

- Cigna Medical, Dental Traditional, Dental EPO and Vision plans are underwritten or administered by Cigna Health and Life Insurance Company (CHLIC).
- Cigna Dental PPO plans are underwritten or administered by CHLIC, with network management services provided by Cigna Dental Health, Inc. and certain of its subsidiaries.
- Cigna Dental Care (DHMO) plans are underwritten or administered by the following operating subsidiaries of Cigna Dental Health, Inc.: Cigna Dental Health Plan of Arizona, Inc., Cigna Dental Health of California, Inc., Cigna Dental Health of Colorado, Inc., Cigna Dental Health of Delaware, Inc., Cigna Dental Health of Florida, Inc., a Prepaid Limited Health Services Organization licensed under Chapter 636, Florida Statutes, Cigna Dental Health of Kansas, Inc. (Kansas and Nebraska), Cigna Dental Health of Kentucky, Inc., Cigna Dental Health of Maryland, Inc., Cigna Dental Health of Missouri, Inc., Cigna Dental Health of New Jersey, Inc., Cigna Dental Health of North Carolina, Inc., Cigna Dental Health of Ohio, Inc., Cigna Dental Health of Pennsylvania, Inc., Cigna Dental Health of Texas, Inc., and Cigna Dental Health of Virginia, Inc. In other states, Cigna Dental Care plans are underwritten or administered by CHLIC or Cigna HealthCare of Connecticut, Inc., and administered by Cigna Dental Health, Inc.
- I agree, for myself and my covered 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, I will fully inform the health plan and will execute such assignments, liens or other documents which may be necessary to enable the health plan to recover the value of the services provided. I further agree that in the event I or any of my covered dependents collect benefits or damages from any other party who has primary responsibility for services provided by the health plan, I will immediately reimburse the health plan to the extent permitted by state law.

FRAUD WARNING

Any person who, knowingly and with intent to defraud any insurance company or other person: (1) files an application for insurance or statement of claim containing any materially false information; or (2) conceals for the purpose of misleading, information concerning any material fact thereto, commits a fraudulent insurance act.

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.

SPECIAL PROVISIONS FOR EMPLOYERS WITH SECTION 125 PLANS

By allowing an individual to enroll in the health plan, other than during the open enrollment period, Cigna Health and Life Insurance Company and its affiliates do not waive any terms of its contract. Further, by allowing an individual to enroll in the health plan, other than during an open enrollment period, Cigna Health and Life Insurance Company and its affiliates do 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.

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