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

Enrollment/Change Form

Please print and thank you for providing this information

Insured and/or Administered by,
CIGNA Health and Life Insurance Company

A

☐ OPEN ENROLL ☐ NEW ENROLL ☐ CHANGE ☐ REINSTATE	EFFECTIVE DATE OF ADD/CHANGE/CANCELLATION (mm/dd/ccyy) ____/____/____	EMPLOYER NAME City of Centennial	EMPLOYER ADDRESS
MEDICAL PLAN NUMBER 607401	SUBGROUP	CLASS	DATE OF HIRE (mm/dd/ccyy) ____/____/____

B

TYPE OF CHANGE
☐ Add Dependent(s) * Date of Coverage (mm/dd/ccyy) ____/____/____
☐ Cancel Employee * Last Date of Coverage (mm/dd/ccyy) ____/____/____
☐ Cancel Dependent(s) * Last Date of Coverage (mm/dd/ccyy) ____/____/____
☐ Address Change (enter new address below) * List Name in Section C

☐ Transfer to COBRA ☐ 18 mos ☐ 29 mos ☐ 36 mos
COBRA Begin Date: ____/____/____

OTHER
☐ Family Security Benefit\ Surviving Spouse
☐ Retirement
☐ Other

C

EMPLOYEE NAME *(Last)*	*(First)*	*(MI)*	SOCIAL SECURITY NUMBER
MAILING ADDRESS *(Street)*	City / State	Zip Code	- -
EMPLOYEE DATE OF BIRTH (mm/dd/ccyy) ____/____/____	HOME PHONE ( )	WORK PHONE ( )	HOME EMAIL ADDRESS / EMPLOYEE IDENTIFICATION NUMBER

☐ YES, I would like Coverage for myself and my dependents (list last name for all dependents) Last Name First Name MI	Relationship	Dependent Social Security Number	Date of Birth mm/dd/ccyy	Gender	Coverage Selection	Check One
Employee			/ /	☐M ☐F	☐ Medical ☐ None	☐ Add ☐ Cancel
Spouse		- -	/ /	☐M ☐F	☐ Medical ☐ None	☐ Add ☐ Cancel
Dependent*		- -	/ /	☐M ☐F	☐ Medical ☐ None	☐ Add ☐ Cancel
Dependent*		- -	/ /	☐M ☐F	☐ Medical ☐ None	☐ Add ☐ Cancel
Dependent*		- -	/ /	☐M ☐F	☐ Medical ☐ None	☐ Add ☐ Cancel

* DEPENDENTS - Dependents are covered under the medical plan to age 26. If totally disabled prior to dependent eligibility end date, attach proof of disability for eligibility review.

D

[MEDICAL				
PPO Medical Care Plans		**CIGNA Open Access Plans - Medical**		***[Select a Medical PCP for OAP Plans]**
☐	PPO	☐	Open Access Plus	
☐	H.S.A. PPO	☐	H.S.A. Open Access Plus	
☐	HRA PPO	☐	HRA Open Access Plus	
☐	CIGNA Consumer Advantage ® PPO	☐	CIGNA Consumer Advantage ® OAP	
		☐	Indemnity	
☐	Decline Coverage	☐	Decline Coverage]	

*Select a Medical Primary Care Physician (PCP) (applicable to: Open Access Plus (OAP), H.S.A. Open Access Plus, HRA Open Access Plus and CIGNA Consumer Advantage ® Open Access Plus plans if offered). Selecting a PCP to help guide your care is optional for all CIGNA OAP Plans.

E

OTHER HEALTHCARE 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 NUMBER	EFFECTIVE DATE	MEDICARE Part A	MEDICARE Part B	MEDICAID	OTHER CARRIER
	- -	____/____/____	☐	☐	☐	
	- -	____/____/____	☐	☐	☐	

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

10CO0.00MO

PROVISIONS

- 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 of services provided and to the extent permitted by state law.

FRAUD WARNING

It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

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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