Form Information

CIGNA Dental Enrollment Form

Employer: Complete Section A
Employee: Complete Sections B, C & D

CIGNA Dental Health, Inc.
Insured dental plans underwritten by
Connecticut General Life Insurance Company
P.O. Box 22170
Tempe, AZ 85285-2170

CIGNA Dental

Please print and thank you for providing this information

A

☐ OPEN ENROLL. ☐ CHANGE
☐ NEW ENROLL. ☐ 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.	DENTAL BENEFIT OPTION

TYPE OF CHANGE:

☐ **Add Dependent(s) *** Date: _____
☐ **Cancel Employee** Last Date of Coverage: _____
☐ **Cancel Dependent(s) *** Last Date of Coverage: _____
Reason for Cancellation:
☐ Leave employment
☐ Transfer out of CIGNA Dental Care area
☐ Transfer to another plan

☐ **Address Change**
☐ **Transfer to COBRA**
☐ 18 mos. ☐ 29 mos. ☐ 36 mos.
☐ **Other** _____

*** List Names in Section C**

B

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)*

WHAT IS YOUR PRIMARY LANGUAGE? *(optional)*

DO YOU HAVE A DISABILITY AFFECTING YOUR ABILITY TO COMMUNICATE OR READ? *(optional)* ☐ Yes ☐ No

SELECT PLAN: ☐ CIGNA Dental Care ☐ CIGNA Dental PPO ☐ ~~CIGNA Dental EPO~~ ☐ ~~CIGNA Traditional~~

C

I WOULD LIKE COVERAGE FOR ME AND MY DEPENDENTS. *(Specify last name if different from yours)* Last Name / First Name / M.I.	DEPENDENT SOCIAL SECURITY NO.	DATE OF BIRTH MM DD CCYY	GENDER	FULL-TIME STUDENT? Yes No	DENTAL OFFICE SELECTION *(for CIGNA Dental Care only)*	START DATE OF CONTINUOUS DENTAL COVERAGE *(for CIGNA Dental PPO only)* *(Month, Day, Year)*	*(check one)*
Employee			☐ M ☐ F		1st Choice - 2nd Choice -		☐ Add ☐ Cancel
Spouse			☐ M ☐ F		1st Choice - 2nd Choice -		☐ Add ☐ Cancel
Dependent Relationship			☐ M ☐ F	☐ ☐	1st Choice - 2nd Choice -		☐ Add ☐ Cancel
Dependent Relationship			☐ M ☐ F	☐ ☐	1st Choice - 2nd Choice -		☐ Add ☐ Cancel
Dependent Relationship			☐ M ☐ F	☐ ☐	1st Choice - 2nd Choice -		☐ Add ☐ Cancel

Please submit proof of student or handicapped status for overage dependents.
The original effective date must be completed for each member in order for continuous coverage credit to be applied toward waiting period.

D

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

NOTE: Not all products are available for all clients or all states. Check your enrollment materials carefully to see what is offered for your group.

Clear Fields

PROVISIONS

- I accept the coverage/insurance benefits provided by this group plan and authorize the processing of my enrollment in the coverage as indicated on this form. I authorize deduction from my earnings of the required contributions, if any, toward the cost of the coverage.
- I authorize payment of benefits to the participating provider.
- I authorize any participating office to release records and billing information concerning me or my dependents to CIGNA Dental Health and Connecticut General Life Insurance Company for purposes of plan administration or for the purpose of validating and determining benefits payable. I further authorize CIGNA Dental Health and Connecticut General Life Insurance Company to release any records or information concerning me or my dependents to its designee, for purposes of plan administration and customer service.
- California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance coverage. CIGNA Dental Health and Connecticut General Life Insurance Company do not require such tests in any state as a condition of obtaining dental coverage.

FRAUD WARNING

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 shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation. (In Florida, this is a felony of the third degree. In New York, the civil penalty is not to exceed five thousand dollars and the stated value of the claim for each such violation. *In Nebraska, "is" is changed to "may be").