Insured and/or Administered by
Connecticut General Life Insurance Company,
a subsidiary of CIGNA Health Corporation
CIGNA HealthCare of New Jersey, Inc.

Enrollment/Change Request

Refer to instructions on back before completing this form.
Print clearly.

Employer Group Information - *To be completed by Employer*

EMPLOYER NAME	CIGNA ACCT. NO.	BRANCH CODE

A. TYPE OF ACTIVITY - *To be completed by Employer*

1. Enrollment
☐ New Enrollee
Effective Date: ___/___/___
Date of Hire: ___/___/___

2. Change - ***Check all that apply.***

	Date of Event	Reason
☐ Add Spouse	___/___/___	
☐ Add Dependent Child	___/___/___	
☐ Name Change	___/___/___	
☐ Change Plan	___/___/___	
☐ Other	___/___/___	

3. Remove or Terminate - ***Check all that apply.***

	Effective Date	Reason
☐ Remove Spouse*	___/___/___	
☐ Remove Dependent Child*	___/___/___	
☐ Employee Withdrawal/Termination	___/___/___	

NOTE: Employee must be enrolled for spouse/dependent(s) to have coverage.
*Please complete *Add/Change/Remove* and *Name* columns in Section D.

4. Continuation of Coverage, i.e., COBRA, State, Total Disability
Not all options are available. Contact Employer for available options.
Coverage For: ☐ Employee ☐ Dependents
Length of Continuation: ☐ 12 mos. ☐ 18 mos. ☐ 29 mos. ☐ 36 mos. ☐ Total Disability*
Date of Loss of Coverage: ___/___/___
Date of Qualifying Event: ___/___/___
Attach proof of total disability

B. EMPLOYEE INFORMATION - Complete Sections B-G

SOCIAL SECURITY NUMBER/EMPLOYEE IDENTIFICATION NUMBER	LAST NAME, FIRST NAME, M.I.		EMPLOYEE DATE OF BIRTH (MM/DD/CCYY)	
HOME TELEPHONE ( )	HOME ADDRESS	APT. NO.	CITY, STATE	ZIP CODE
EMPLOYER NAME			WORK TELEPHONE ( )	
WORK ADDRESS		CITY, STATE		ZIP CODE
DATE OF EMPLOYMENT		HOURS WORKED PER WEEK		

C. PLAN OPTION - Your selection must be offered by your employer. *Check One.*

MANAGED CARE MEDICAL OPTIONS:
☐ Point-of-Service (or DPP or CHA)
☐ HMO
☐ Network (or EPP) (ASO only)
☐ Point-of-Service Open Access
☐ HMO Open Access
☐ Network Open Access (ASO only)
☐ Open Access Plus
☐ Open Access Plus In-Network (ASO only)
☐ CIGNA Care Network (ASO only)
☐ Decline Coverage

OPTION # *(if applicable):* ☐ 1 ☐ 2 ☐ 3

OTHER MEDICAL OPTIONS:
☐ Preferred Provider Option (PPO)
☐ In-Network PPO or EPO (ASO only)
☐ Preferred Provider Access (PPA)
☐ Medical Indemnity
☐ _____

CIGNA CHOICE FUND℠ OPTIONS:
☐ HRA ☐ with PPO
☐ HSA ☐ with Open Access Plus
☐ Pharmacy HRA ☐ with Open Access Plus In-Network (ASO only)
☐ Dental HRA ☐ with EPO (ASO only)
☐ with Indemnity

CIGNA Choice Fund Annual Amount: _____

DENTAL OPTIONS: ☐ CIGNA Dental Care (CDC) ☐ Dental PPO ☐ Dental Indemnity ☐ Decline Coverage

D. INDIVIDUALS COVERED - List individuals for whom you are adding/changing/removing coverage. Attach sheet to list additional children. Attach proof if full-time college student. Attach proof of disability.

	(A)dd (C)hange (R)emove	LAST NAME, FIRST NAME, M.I.	SEX M	SEX F	BIRTHDATE MM DD YYYY	SOCIAL SECURITY NUMBER	OTHER HEALTH COVERAGE? Yes	PRIMARY OFFICE ID NUMBER	CURRENT PATIENT? Yes	DENTAL OFFICE ID NUMBER *(if applicable)*	CURRENT PATIENT? Yes	PREVIOUS COVERAGE? Yes
Employee			☐	☐			☐		☐		☐	☐
Spouse			☐	☐			☐		☐		☐	☐
Child			☐	☐			☐		☐		☐	☐
Child			☐	☐			☐		☐		☐	☐
Child			☐	☐			☐		☐		☐	☐

E. OTHER/PREVIOUS INSURANCE

IS YOUR SPOUSE EMPLOYED? ☐ Yes ☐ No IF "YES", GIVE NAME & ADDRESS OF SPOUSE'S EMPLOYER

IF "YES" TO OTHER HEALTH COVERAGE (SECTION D), GIVE NAME & POLICY NUMBER OF INSURANCE CARRIER, HMO, OR OTHER SOURCE.
IF ENROLLED IN MEDICARE PARTS A AND/OR B, IDENTIFY THE COVERAGE AND PROVIDE THE MEDICARE ID #.

IF "YES" TO PREVIOUS COVERAGE (SECTION D), IDENTIFY NAME(S) OF PERSONS, GIVE EFFECTIVE DATE AND DATE COVERAGE TERMINATED, NAME OF PREVIOUS CARRIER AND PLAN NUMBER.

F. DEPENDENT INFORMATION

DOES ANY DEPENDENT LISTED IN SECTION D LIVE AT A DIFFERENT ADDRESS THAN THE EMPLOYEE? ☐ Yes ☐ No IF "YES", WHO AND WHAT ADDRESS?

EXPLAIN THE CIRCUMSTANCES

IF ANY DEPENDENT'S LAST NAME DIFFERS FROM YOURS, EXPLAIN THE CIRCUMSTANCES.

If you have questions concerning the benefits and services provided by or excluded under this Plan or Group Policy, contact a CIGNA HealthCare representative at 1-800-244-6224 (option 3) before signing this form.

G. EMPLOYEE SIGNATURE

I represent that all the information supplied in this application is true and complete. I hereby agree to the conditions of enrollment on the reverse side of the employee copy of this enrollment/change request. I authorize deductions from my earnings for any required contributions.

EMPLOYEE SIGNATURE - ***Required***
X

DATE ___/___/___ | E-MAIL ADDRESS

H. EMPLOYER VERIFICATION - *To be completed by Employer*

EMPLOYER SIGNATURE - ***Required***
X

TITLE | DATE ___/___/___

Employee copy may be used as a temporary ID card for 30 days from the effective date if authorized by employer. Coverage must be verified with CIGNA HealthCare prior to visiting a specialist or admission to a hospital.

INSTRUCTIONS

EMPLOYER

- Complete the **Employer Group Information** in the upper right corner of the form.
- **Section A - Type of Activity:** Check box(es) indicating reason(s) for submitting enrollment/change request.
- Complete **Section H - Employer Verification** in the lower right corner of the form.
  - Employer must complete this section for all new enrollments, coverage changes and terminations.
  - Employer must sign and date the application in order for it to be processed.

EMPLOYEE - Complete Sections B-G

Section B - Employee Information:

Complete **all** information in order for your enrollment/change request to be processed.

Section C - Plan Option:

- Check one Plan Option box, indicate Plan Option Name (where applicable) and check *one* Primary Copay and/or Individual Deductible Amount (if applicable).
- Select only an option offered by your employer.

Section D - Individuals Covered:

- Add/Change/Remove - Use "A", "C", or "R" to indicate whether you are adding, changing or removing coverage for an individual.
- Print your full name along with the name(s) of your dependent(s), if applicable. Indicate Sex, Birthdate, and Social Security Number for each individual listed.
- If a dependent is a full-time college student, you must attach a current course schedule or a letter from the school confirming full-time student status (12 or more credits). If dependent is disabled and being continued beyond the limiting age, attach proof of disability.
- If you or your dependent(s) have other Health coverage, check off the "Yes" box(es) and complete Section E - Previous Insurance.
- From the appropriate provider directory, locate the **10-digit** office ID number for the primary care physician, ob/gyn (if applicable) and/or dentist (if applicable). Indicate office ID number selection(s) on the form.
- If you are a current patient, please check the "Current Patient" box.

Section E - Previous Insurance:

Complete this section for all new enrollments or coverage changes. Coverage includes group coverage, governmental coverage, a church plan or Medicare.

Section F - Dependent Information:

Complete this section for all new enrollments or coverage changes.

Section G - Employee Signature:

- Complete this section for all new enrollments, coverage changes and terminations.
- Employee must sign and date the enrollment/change request in order for it to be processed.

Section H - Employer Verification:

- Employer must complete this section for all new enrollments, coverage changes and terminations.
- Employer must sign and date the enrollment/change request in order for it to be processed.

CONDITIONS OF ENROLLMENT

Applicant Acknowledgments and Agreements

On behalf of myself and the dependents listed on the reverse side, I agree to or with the following:

1. a) I authorize the sources stated below to give to CIGNA HealthCare or Connecticut General Life Insurance Company, or any consumer reporting agency acting on its behalf, information about me and my minor children, if applying for coverage. Such information will pertain to employment, other health coverage, and medical advice, treatment or supplies for any physical or mental condition. Authorized sources are: any physician or medical professional; any hospital, clinic or other medical care institution; any carrier; any consumer reporting agency; any employer.

   b) I understand that I may revoke this authorization at any time. I agree that such revocation will not affect any action which CIGNA HealthCare or Connecticut General Life Insurance Company has taken in reliance on the authorization. I understand this authorization will not be valid after 30 months, if not revoked earlier.

   c) I know that I have a right to receive a copy of this authorization if I request one.

   d) I agree that a photocopy of this authorization is as valid as the original.

2. I acknowledge by enrolling in a CIGNA HealthCare or Connecticut General Life Insurance Company plan or group policy, coverage is provided by CIGNA HealthCare or Connecticut General Life Insurance Company in accordance with the contract.
3. Enrollment of myself and of the listed dependents into the plan is effective on acceptance by CIGNA HealthCare or Connecticut General Life Insurance Company.
4. Coverage and benefits are contingent on timely payment of premiums and may be terminated as provided in the plan documents. My employer is hereby authorized to withhold payments from my wages, as appropriate.

Misrepresentation

5. Any person who includes any false or misleading information on an application or enrollment form for a health benefits plan is subject to criminal and civil penalties.