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

CIGNA

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
	EWRSD	

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
3212804								

TYPE OF CHANGE:

☐ **Add Dependent(s) *** Date:__________
☐ **Cancel Employee** Last Date of Coverage: __________
☐ **Cancel Dependent(s) *** Last Date of Coverage: __________
*** List Names in Section B**

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

☐ **Family Security Benefit/Surviving Spouse**
☐ **Retirement**
☐ **Other** __________

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)*

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	GEN-DER	COVERAGE SELECTION	FULL TIME STUDENT? * Yes / No	POS: *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? Yes / No	DHMO: *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? Yes / No	*(check one)*
Employee			☐M ☐F	☐Medical ☐Dental		PCP or HCC Choice -	☐ ☐	1st Choice - / 2nd Choice -	☐ ☐ / ☐ ☐	☐Add ☐Cancel
Spouse			☐M ☐F	☐Medical ☐Dental		PCP or HCC Choice -	☐ ☐	1st Choice - / 2nd Choice -	☐ ☐ / ☐ ☐	☐Add ☐Cancel
Dependent * Relationship			☐M ☐F	☐Medical ☐Dental	☐ ☐	PCP or HCC Choice -	☐ ☐	1st Choice - / 2nd Choice -	☐ ☐ / ☐ ☐	☐Add ☐Cancel
Dependent * Relationship			☐M ☐F	☐Medical ☐Dental	☐ ☐	PCP or HCC Choice -	☐ ☐	1st Choice - / 2nd Choice -	☐ ☐ / ☐ ☐	☐Add ☐Cancel
Dependent * Relationship			☐M ☐F	☐Medical ☐Dental	☐ ☐	PCP or HCC Choice -	☐ ☐	1st Choice - / 2nd Choice -	☐ ☐ / ☐ ☐	☐Add ☐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.

C

MANAGED CARE MEDICAL OPTIONS:
☐ Point-of-Service ($10 Co-Pay)

OTHER MEDICAL OPTIONS:
☐ Preferred Provider Option (PPO)

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):

D

E

DENTAL OPTIONS:
☐ CIGNA Dental Care (DHMO)
☐ Dental PPO

*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.

F

OTHER HEALTH CARE 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 NO.	EFFECTIVE DATE	MEDICARE Part A	MEDICARE Part B	MEDICAID	OTHER INSURANCE CARRIER
			☐	☐	☐	☐
			☐	☐	☐	☐

G

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