Date: _____

CIGNA HealthCare
Attention: Small Group Service Department
701 Corporate Center Drive
Raleigh, NC 27607
877-365-2153 (fax)

Dear Client Service Representative:

The following employees of _____ (Company Name) have had continuous coverage with _____ (Prior Carrier) over all or part of the last 12 months:

Last Name	First Name	Social Security #	**Effective date w/prior carrier**	**End Date w/prior carrier**	Coverage Level: EE, ES, EC, Fam

_____

Signature/Title