

Enrollment / Change Form

Employer: Complete Section A
 Employee: Complete Sections B-E

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



Please print and thank you for providing this information

A	<input type="checkbox"/> OPEN ENROLL. <input type="checkbox"/> CHANGE <input type="checkbox"/> NEW ENROLL. <input type="checkbox"/> REINSTATE		EFFECTIVE DATE OF ADD/CHANGE/ CANCELLATION (MM/DD/CCYY)	EMPLOYER NAME	EMPLOYER ADDRESS		
	CIGNA ACCOUNT NO.	COVERAGE TYPE	DATE OF HIRE (MM/DD/CCYY)	NETWORK ID	BRANCH CODE		
	TYPE OF CHANGE: <input type="checkbox"/> Add Dependent(s) * Date: _____ <input type="checkbox"/> Cancel Employee Last Date of Coverage: _____ <input type="checkbox"/> Cancel Dependent(s) * Last Date of Coverage: _____ * List Names in Section B						

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)		DEPENDENT SOCIAL SECURITY NO.	DATE OF BIRTH	GENDER	FULL TIME STUDENT? *	Select your choice of Primary Care Physician (PCP) or HealthCare Center (HCC) and enter the ID Numbers below.	EXISTING PATIENT?	(check one)			
	Last Name	First Name	M.I.	MM	DD	CCYY	Yes	No	Yes	No	Add	Cancel
Employee						<input type="checkbox"/> M <input type="checkbox"/> F						<input type="checkbox"/> Add <input type="checkbox"/> Cancel
Spouse						<input type="checkbox"/> M <input type="checkbox"/> F						<input type="checkbox"/> Add <input type="checkbox"/> Cancel
Dependent *		Relationship				<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/>	<input type="checkbox"/>				<input type="checkbox"/> Add <input type="checkbox"/> Cancel
Dependent *		Relationship				<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/>	<input type="checkbox"/>				<input type="checkbox"/> Add <input type="checkbox"/> Cancel
Dependent *		Relationship				<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/>	<input type="checkbox"/>				<input type="checkbox"/> Add <input type="checkbox"/> 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:	CIGNA HealthCare of North Carolina, Inc. <input type="checkbox"/> HMO <input type="checkbox"/> HMO Open Access	CIGNA HealthCare of North Carolina, Inc. (in-network benefits) Connecticut General Life Insurance Co. (out-of-network benefits) <input type="checkbox"/> Point-of-Service <input type="checkbox"/> Point-of-Service Open Access
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D	OTHER HEALTH CARE COVERAGE: Do you or your dependents have other health insurance under a group plan, HMO, or Medicare? <input type="checkbox"/> Yes <input type="checkbox"/> 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	
	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

E	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

FRAUD WARNING

Any person who, knowingly and with intent to defraud any insurance company or other person: (1) files an application for insurance or statement of claim containing any materially false information; or (2) conceals for the purpose of misleading, information concerning any material fact thereto, commits a fraudulent insurance act.

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 PROVISION FOR EMPLOYERS WITH SECTION 125 PLANS

By allowing an individual to enroll in the Insurance Plan other than during the open enrollment period, CIGNA HealthCare or Connecticut General Life Insurance Company does not waive any terms of its contract. Further, by allowing an individual to enroll in the Insurance Plan other than during an open enrollment period, CIGNA HealthCare or Connecticut General Life Insurance Company does 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.