

Enrollment / Change Form - HMO



Employer: Complete Section A

Employee: Complete Sections B-E

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		
<p>TYPE OF CHANGE:</p> <div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> <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: _____ </div> <div style="width: 45%;"> <input type="checkbox"/> Address Change <input type="checkbox"/> Transfer to COBRA <input type="checkbox"/> 18 mos. <input type="checkbox"/> 29 mos. <input type="checkbox"/> 36 mos. </div> <div style="width: 45%;"> <input type="checkbox"/> Retirement <input type="checkbox"/> Other _____ </div> </div> <p>* List Names in Section B</p>							

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. <i>(Specify last name if different from yours)</i>			Dependent Social Security No.	Date of Birth MM DD CCYY	Gender	Full Time Student? * Yes No	<i>Select your choice of Primary Care Physician (PCP) or HealthCare Center (HCC) and enter the ID Numbers below.</i>		Existing Patient? Yes No	(check one)
	Last Name	First Name	M.I.			<input type="checkbox"/> M <input type="checkbox"/> F			PCP or HCC Choice -	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Add <input type="checkbox"/> Cancel
Employee					<input type="checkbox"/> M <input type="checkbox"/> F			PCP or HCC Choice -	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Add <input type="checkbox"/> Cancel	
Spouse					<input type="checkbox"/> M <input type="checkbox"/> F			PCP or HCC Choice -	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Add <input type="checkbox"/> Cancel	
Dependent *	Relationship				<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Yes <input type="checkbox"/> No		PCP or HCC Choice -	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Add <input type="checkbox"/> Cancel	
Dependent *	Relationship				<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Yes <input type="checkbox"/> No		PCP or HCC Choice -	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Add <input type="checkbox"/> Cancel	
Dependent *	Relationship				<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Yes <input type="checkbox"/> No		PCP or HCC Choice -	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Add <input type="checkbox"/> Cancel	
<p>* 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.</p>											

C	MANAGED CARE MEDICAL OPTIONS:			
	<input type="checkbox"/> HMO	<input type="checkbox"/> Point-of-Service (CHA)	<input type="checkbox"/> HMO Open Access	<input type="checkbox"/> Point-of-Service Open Access

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		Medicaid Other Insurance Carrier
						Part A Part B			
						<input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/> <input type="checkbox"/>	
						<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

PROVISIONS

- "CIGNA HealthCare" refers to various operating subsidiaries of CIGNA Corporation. Products and services are provided by these subsidiaries and not by CIGNA Corporation. These subsidiaries include Connecticut General Life Insurance Company, Tel-Drug, Inc. and its affiliates, CIGNA Behavioral Health, Inc., Intracorp, and HMO or service company subsidiaries of CIGNA Health Corporation and CIGNA Dental Health, Inc.
- I agree, for myself and my dependents, that, in the event any health services provided are the primary responsibility of any third party by way of other group health coverage or by the act or omission of another person to fully inform the healthplan and will execute such assignments, liens or other documents which may be necessary to enable the healthplan to recover the value of the services provided. I further agree that in the event I or any of my dependents collect benefits or damages from any third party who has primary responsibility for services provided by the healthplan, I will immediately reimburse the healthplan to the extent of services provided, to the extent permitted by state law.

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.