Primary Applicant Name_____
Enrollment Form ID_____

Cigna Health and Life Insurance Company
North Carolina Individual and Family Plan Enrollment Application / Change Form

Section A. Type of Application

New Enrollment Application:
☐ Applicant Only ☐ Applicant and Dependent(s) ☐ Child(ren) Only

Existing Individual Plan Policy Member requesting a change in coverage:
☐ Add Family Member(s) or ☐ Request Plan Change

Subscriber Name:_____ Subscriber ID:_____

Requested Effective Date:*
☐ 1st of the Month of _____
Effective dates are assigned to the 1st of the month. Cigna Health and Life Insurance Company will assign the next available effective date if not selected by the applicant.

** Requested Effective Date cannot be greater than 60 days after the Signature Date. No Effective Dates will be assigned prior to or on the Signature Date.*

Section B. Enrollment Criteria

Applications are accepted during annual open enrollment period or when an applicant experiences a Qualifying (Triggering) Life Event. Please select the applicable enrollment reason.

☐ Annual Open Enrollment

☐ Special Enrollment Period *(Select the qualifying event below).*

To apply for Special Enrollment Period an applicant must experience a Qualifying (Triggering) Life Event and has 60 days from the date of that event, (including the date of the actual event) to apply for coverage. Triggering events **do not** include loss of coverage due to failure to make premium payments on a timely basis, including COBRA premiums prior to expiration of COBRA coverage; and situations allowing for a rescission under federal law. Please select the applicable qualifying event reason(s) and date(s) below in order to determine your effective date and plan eligibility. Valid documentation will be required to be submitted for all Special Enrollment events.

- ☐ An eligible individual, and any dependent(s), loses his or her minimum essential coverage for reasons other than the reasons stated above
- ☐ An eligible individual gained or became a dependent through marriage or civil union
- ☐ An eligible individual gained or became a dependent through birth, adoption, or placement for adoption, or placement in foster care
- ☐ An eligible individual experienced an error in enrollment
- ☐ An eligible individual or enrollee made a permanent move and new coverage is available
- ☐ An eligible individual and his or her dependent(s) lose employer-sponsored health plan coverage due to involuntary termination of employment for reasons other than misconduct, or due to a reduction in work hours
- ☐ An eligible dependent spouse or child loses coverage under an employer-sponsored health plan due to employee's becoming entitled to Medicare, divorce or legal separation of the covered employee, and death of the covered employee
- ☐ An eligible individual loses his or her dependent child status under a parent's employer-sponsored health plan
- ☐ An eligible individual is mandated to be covered as a dependent pursuant to a valid court order, including child support

For any Special Enrollment Period reason, provide:
Name(s): _____ and Event Date(s): _____

Section C. Benefit Plan Options

Select Desired Medical Benefit Plan:
☐ Cigna Access HSA Bronze 6200
☐ Cigna Access Flex Silver 4000
☐ Cigna Access Flex Gold 1250

Select Desired Dental Benefit Plan:
☐ Cigna Dental Preventative
☐ Cigna Dental 1000
☐ Cigna Dental 1500

Primary:	☐ Medical	☐ Dental
Spouse (or Domestic Partner/Civil Union):	☐ Medical	☐ Dental
Dependent 1:	☐ Medical	☐ Dental
Dependent 2:	☐ Medical	☐ Dental

Primary Applicant Name_____ Enrollment Form ID_____

Section D. Applicant, Spouse and Dependent Information - Dependent children are not required to reside with parent or within insurer's service area

Applicant's Last Name:	First Name:	M.I.	iTIN: Social Security Number:

Date of Birth:	Age:	☐ Single ☐ Married	☐ Male ☐ Female	Select your choice of Primary Care Physician (PCP). First Name: _____ Last Name: _____ PCP ID Number: _____ *Plans with this asterisk mean a PCP is required. If you do not select a PCP, one will be assigned for you. Current Patient: ☐ Yes ☐ No

Custodial Parent or Legal Guardian Name (for applicants under the age of 18):	Relationship to Applicant:

Mailing Address – Home Address Required Street City State ZIP Code (Please provide 9-digit ZIP Code)	Billing Address – If different than mailing address P.O. Box / Street City State ZIP Code	County	Home Phone Number: ( ) _____-_____ Cell Phone Number: ( ) _____-_____ Work Phone Number: ( ) _____-_____ Email Address:

Applicant's Language Preference
Spoken Language Preference (Select only one)

☐ EN English ☐ ES Spanish ☐ 12 Cantonese ☐ 14 Mandarin ☐ VI Vietnamese ☐ KO Korean ☐ TL Tagalog
☐ HY Armenian ☐ JA Japanese ☐ PS Persian ☐ PA Punjabi ☐ LO Khmer ☐ AR Arabic ☐ 03 White Hmong
☐ 28 Blue/Green Hmong ☐ RU Russian ☐ Declines to State ☐ 99 Other _____
Please Write In

Written Language Preference (Select only one)

☐ EN English ☐ ES Spanish ☐ 20 Traditional Chinese ☐ VI Vietnamese ☐ KO Korean ☐ TL Tagalog ☐ HY Armenian
☐ JA Japanese ☐ PS Persian ☐ PA Punjabi ☐ LO Khmer ☐ AR Arabic ☐ 03 White Hmong ☐ 28 Blue/Green Hmong
☐ RU Russian ☐ Declines to State ☐ 99 Other _____
Please Write In

Spouse/Domestic Partner/Civil Union's Last Name	First Name	M.I.	iTIN: Social Security Number:

Date of Birth:	Age:	☐ Single ☐ Married	☐ Male ☐ Female	Select your choice of Primary Care Physician (PCP). First Name: _____ Last Name: _____ PCP ID Number: _____ *Plans with this asterisk mean a PCP is required. If you do not select a PCP, one will be assigned for you. Current Patient: ☐ Yes ☐ No

Does this person live at the same address as the Applicant? ☐ Yes ☐ No
If no, list address (Street, City, State, 9-digit ZIP Code and County):
_____

Spouse/Domestic Partner/Civil Union's Language Preference
Spoken Language Preference (Select only one)

☐ EN English ☐ ES Spanish ☐ 12 Cantonese ☐ 14 Mandarin ☐ VI Vietnamese ☐ KO Korean ☐ TL Tagalog
☐ HY Armenian ☐ JA Japanese ☐ PS Persian ☐ PA Punjabi ☐ LO Khmer ☐ AR Arabic ☐ 03 White Hmong
☐ 28 Blue/Green Hmong ☐ RU Russian ☐ Declines to State ☐ 99 Other _____
Please Write In

Written Language Preference (Select only one)

☐ EN English ☐ ES Spanish ☐ 20 Traditional Chinese ☐ VI Vietnamese ☐ KO Korean ☐ TL Tagalog ☐ HY Armenian
☐ JA Japanese ☐ PS Persian ☐ PA Punjabi ☐ LO Khmer ☐ AR Arabic ☐ 03 White Hmong ☐ 28 Blue/Green Hmong
☐ RU Russian ☐ Declines to State ☐ 99 Other _____
Please Write In

Primary Applicant Name_____ Enrollment Form ID_____

Dependent children are covered up to age 26.
☐ Check here if you are providing names of additional dependents on an attached separate page.

Dependent's Last Name	First Name	M.I.	iTIN: Social Security Number:

Date of Birth:	Age:	☐ Single ☐ Married	☐ Male ☐ Female	Select your choice of Primary Care Physician (PCP). First Name: _____ Last Name: _____ PCP ID Number: _____ *Plans with this asterisk mean a PCP is required. If you do not select a PCP, one will be assigned for you. Current Patient: ☐ Yes ☐ No

Does this person live at the same address as the Applicant? ☐ Yes ☐ No
If no, list address (Street, City, State, 9-digit ZIP Code and County):
_____

Dependent's Language Preference
Spoken Language Preference (Select only one)

☐ EN English ☐ ES Spanish ☐ 12 Cantonese ☐ 14 Mandarin ☐ VI Vietnamese ☐ KO Korean ☐ TL Tagalog
☐ HY Armenian ☐ JA Japanese ☐ PS Persian ☐ PA Punjabi ☐ LO Khmer ☐ AR Arabic ☐ 03 White Hmong
☐ 28 Blue/Green Hmong ☐ RU Russian ☐ Declines to State ☐ 99 Other _____
Please Write In

Written Language Preference (Select only one)

☐ EN English ☐ ES Spanish ☐ 20 Traditional Chinese ☐ VI Vietnamese ☐ KO Korean ☐ TL Tagalog ☐ HY Armenian
☐ JA Japanese ☐ PS Persian ☐ PA Punjabi ☐ LO Khmer ☐ AR Arabic ☐ 03 White Hmong ☐ 28 Blue/Green Hmong
☐ RU Russian ☐ Declines to State ☐ 99 Other _____
Please Write In

Dependent's Last Name	First Name	M.I.	iTIN: Social Security Number:

Date of Birth:	Age:	☐ Single ☐ Married	☐ Male ☐ Female	Select your choice of Primary Care Physician (PCP). First Name: _____ Last Name: _____ PCP ID Number: _____ *Plans with this asterisk mean a PCP is required. If you do not select a PCP, one will be assigned for you. Current Patient: ☐ Yes ☐ No

Does this person live at the same address as the Applicant? ☐ Yes ☐ No
If no, list address (Street, City, State, 9-digit ZIP Code and County):
_____

Dependent's Language Preference
Spoken Language Preference (Select only one)

☐ EN English ☐ ES Spanish ☐ 12 Cantonese ☐ 14 Mandarin ☐ VI Vietnamese ☐ KO Korean ☐ TL Tagalog
☐ HY Armenian ☐ JA Japanese ☐ PS Persian ☐ PA Punjabi ☐ LO Khmer ☐ AR Arabic ☐ 03 White Hmong
☐ 28 Blue/Green Hmong ☐ RU Russian ☐ Declines to State ☐ 99 Other _____
Please Write In

Written Language Preference (Select only one)

☐ EN English ☐ ES Spanish ☐ 20 Traditional Chinese ☐ VI Vietnamese ☐ KO Korean ☐ TL Tagalog ☐ HY Armenian
☐ JA Japanese ☐ PS Persian ☐ PA Punjabi ☐ LO Khmer ☐ AR Arabic ☐ 03 White Hmong ☐ 28 Blue/Green Hmong
☐ RU Russian ☐ Declines to State ☐ 99 Other _____
Please Write In

D1. Are all enrollees residents of the United States? ☐Yes ☐No
If you answered "No" to the above question, provide names of non residents:
_____

D2. Do all enrollees reside within North Carolina and within the service area of the selected benefit plan? ☐Yes ☐No
If you answered "No" to the above question, provide names of non residents:
_____

Cigna Health and Life Insurance Company Use Only:	Effective Date:

Section E. Current Coverage and Additional Prior Coverage Information

To be completed when purchasing a medical plan.

E1. Does any applicant(s) have current health care coverage? ☐Yes ☐No

E2. If any applicant answered "Yes" to any of the above, please provide the following information:
Applicants Covered: _____
Most Recent Coverage Start Date: _____ Termination Date: _____

E3. Does this information apply to all family members on this application? ☐Yes ☐No
If "No", please add additional coverage information in the space provided below.

Applicant #1 Name: _____
Most recent health coverage start date: (MM/DD/YYYY): _____ Termination date: (MM/DD/YYYY): _____

Applicant #2 Name: _____
Most recent health coverage start date: (MM/DD/YYYY): _____ Termination date: (MM/DD/YYYY): _____

Applicant #3 Name: _____
Most recent health coverage start date: (MM/DD/YYYY): _____ Termination date: (MM/DD/YYYY): _____

To be completed when purchasing a Dental Plan.

E4. Does any applicant(s) have current dental care coverage? ☐Yes ☐No

E5. If any applicant answered "Yes" to any of the above, please provide the following information:
Applicants Covered: _____
Most Recent Coverage Start Date: _____ Termination Date: _____

E6. Does this information apply to all family members on this application? ☐Yes ☐No
If "No", please add additional coverage information in the space provided below.

Applicant #1 Name: _____
Most recent dental coverage start date: (MM/DD/YYYY): _____ Termination date: (MM/DD/YYYY): _____

Applicant #2 Name: _____
Most recent dental coverage start date: (MM/DD/YYYY): _____ Termination date: (MM/DD/YYYY): _____

Applicant #3 Name: _____
Most recent dental coverage start date: (MM/DD/YYYY): _____ Termination date: (MM/DD/YYYY): _____

Section F. Health Related Questions

F1. Has any applicant over the age of 18, smoked or used tobacco products on average for four (4) or more times per week within the past six months (includes chewing tobacco, cigarettes, cigars and pipes, excludes religious or ceremonial use of tobacco)? ☐Yes ☐No

If yes, list applicant name(s) and the last time they smoked or used tobacco products:

Name(s): _____

Section G. Important Information

1. ☐ I prefer to receive written correspondence regarding this application via email.

2. Do not cancel your current coverage until you have received notification from Cigna Health and Life Insurance Company.

Section H. Payment Method

NOTE: Electronic Funds Transfer - EFT (Automatic draft from a checking or savings account) and Credit Card are the only initial payment methods allowed for online or faxed applications. The accounts will be charged only upon approval of your Application.

Initial Premium Payment Method:

☐ Electronic Funds Transfer (EFT) ☐ Automatic Credit Card Payment ☐ Paper Check

Electronic Funds Transfer – EFT (Automatic draft from a checking or savings account)

☐ Yes, I am requesting EFT both for my initial payment and for ongoing monthly payments (no paper or electronic monthly billing statement will be issued).

☐ Yes, I am requesting EFT for my initial payment. I agree that I am responsible for initiating all subsequent electronic monthly payments. I am requesting monthly electronic bills (eBills) to be sent to my email account as provided in Section D of this application.

Account Number:_____ ☐ Checking ☐ Saving

Routing Number: ☐☐☐☐☐☐☐☐☐

Name of Bank:_____ Name(s) on Account:_____

I authorize the Company (Cigna Health and Life Insurance Company) to make monthly withdrawals, in the amount of my monthly premium, from my bank account as identified on this form and authorize the banking facility (Bank) to charge such withdrawals to my account. This authority will remain in effect until the Company receives written notice from me that the authority is terminated. Such termination will be effective with respect to the next premium due following 21 days after the written notice is received by the Company. I understand that if for any reason, a withdrawal is not honored by the Bank (including, but not limited to, insufficient funds or my direction to the Bank not to honor the withdrawal) my health care contract premium will be unpaid, and failure to pay my health care contract premium may result in termination for my health care contract, that I may be charged an administration fee in addition to my healthcare premium, and that this authorization will remain in place until cancelled and that any due or past due premiums may be withdrawn under this authorization. I understand and agree that termination of this authorization does not relieve me of responsibility for charges incurred under my health care contract. I agree to indemnify and hold harmless the Company and its affiliates and employees for any claims arising out of transfers or deductions from my account in accordance with this authorization.

Any premium adjustment will automatically be charged to your account. Please be advised that the premium adjustment may reflect an increase.

Credit Card (Available for initial payment only) ☐ VISA ☐ MASTERCARD

Cardholder's Name – exactly as it appears on the card:

Account Number:
☐☐☐☐-☐☐☐☐-☐☐☐☐-☐☐☐☐

Card Expiration Date:

Account Holder's ZIP Code: _____ – _____ 3-digit Code: _____

Any premium adjustment will automatically be charged to your account. Please be advised that the premium adjustment may reflect an increase.

For Paper Application: ***Please check here:*** ☐ Paper check is attached or ☐ Credit card information provided.

Ongoing Payment Options if paying by paper check or credit card for initial payment (please select one option only)

☐ **Monthly Paper Bill:** Yes, I am submitting a paper check (or have selected the credit card option) for my initial payment. I will submit a check for my ongoing monthly payments.

☐ **EFT Draft:** Yes, I am submitting a paper check for my initial payment (or have selected the credit card option) and I am requesting recurring automatic EFT drafts for ongoing monthly payments. (No paper or electronic monthly or quarterly billing statements will be issued.) *Please complete the EFT section above.*

☐ **Monthly Electronic Bill (eBill):** Yes, I am submitting a paper check (or have selected the credit card option) for my initial payment and agree that I am responsible for initiating all subsequent electronic monthly payments. I am requesting monthly electronic bills (eBills) to be sent to my email account provided in Section D of this application.

For Online electronic submitted Application:
Ongoing Payment Options if Credit Card Option was selected for initial payment (please select one option only).

☐ **EFT Draft:** Yes, I agree to recurring automatic EFT drafts for my ongoing monthly payments. (No paper or electronic monthly billing statement will be issued.) Please complete the EFT section above.

☐ **Monthly Electronic Bill (eBill):** Yes, I agree that I am responsible for initiating my ongoing electronic monthly payments. I am requesting monthly electronic bills (eBills) to be sent to my email account as provided in Section D of this application.

Section I. Statement of Accountability – *To be completed when applicant cannot complete the application.*

I, _____, personally read and completed this Enrollment Application Form for the Applicant named below because:

☐ Applicant does not read English ☐ Applicant does not speak English ☐ Applicant does not write English

☐ Other (explain):_____

I personally translated the contents of this application disclosed by:

_____

I also personally translated and fully explained the Conditions and Agreement Section:

_____ _____

Signature of Translator *required* (*Excludes Parent Signature if Child Only Application*) | Today's Date *required*

Section J. Producer Section

Writing Producer Name:	Producer Code:	
Street Address:	City:	State: ZIP Code:
Email Address:	Phone Number:	
Are you aware of any information about your client not disclosed on this application?		☐ Yes ☐ No
Did you see the proposed applicant at the time this application was completed? If "No", please explain:_____		☐ Yes ☐ No

I verify that the application was completed by the applicant unless otherwise noted in the Statement of Accountability.

"Writing Producer's Statement: I certify that the answers given to the questions in this application were provided by the primary applicant and the applicant was instructed that all information must be accurate and complete. I certify that I have truly and accurately recorded on the application the information supplied by the primary applicant. I understand that commissions cannot be paid unless I am appointed with Cigna Health and Life Insurance Company."

Signature of Writing Producer:		Date:
Please enter the name of the Agency/Producer that checks are to be made payable to if different from Writing Producer.		Producer Code:
Street Address:	City:	State: ZIP Code:
Email Address:	Phone Number:	
Cigna Health and Life Insurance Company Sales Representative Last Name:		First Name:

Section K. Instructions

- The applicant is responsible for ensuring that the application is complete and truthful.
- Print clearly using black or blue ink.
- The application must be received by Cigna Health and Life Insurance Company within 30 days from the signature date.
- Any fraudulent misrepresentation or intentional omission of any applicant will render this contract null and void from its date of issue in accordance with applicable law.
- Coverage will become effective only if this application enrollment form is accepted and appropriate premium is enclosed.
- Do not cancel your current coverage until you have received notification from Cigna Health and Life Insurance Company.
- Effective dates are generally assigned to the 1st of the month. The next available effective date will be assigned, if not selected by the applicant.

Section L. Conditions and Agreement/Authorization

1. I understand that any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any material false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act and may be subject to civil and criminal penalties.
2. I authorize that payment be made under Part B of Medicare to Cigna Health and Life Insurance Company for medical and other services furnished by Cigna Health and Life Insurance Company for which it pays or has paid, if applicable.
3. I agree that in the event health services provided or covered are the primary responsibility of Medicare, Cigna Health and Life Insurance Company may be authorized by applicable law to pursue, to fully inform Cigna Health and Life Insurance Company and execute such documents and provide such assistance as may be necessary to enable Cigna Health and Life Insurance Company to recover the value of services provided, arranged or covered.
4. I understand that I or my authorized representative is entitled to receive a copy of this authorization form.
5. I understand that information disclosed pursuant to this Authorization may be subject to re-disclosure by the receipient and will no longer be protected by federal privacy regulations.
6. I authorize use of a copy of this form (including an electronic copy) as authorization to disclose any personal or privileged information to Cigna Health and Life Insurance Company, companies affiliated with Cigna Health and Life Insurance Company or other persons or entities authorized by Cigna Health and Life Insurance Company. This authorization expires thirty (30) months after the date I sign this application.
7. If the applicant is a minor, I accept full legal and financial responsibility for the coverage and information provided on this application. (Court documents establishing guardianship must be submitted if the responsible adult is not the parent).

If a social security number is not provided on this application, Cigna Health and Life Insurance Company will issue a Cigna Health and Life Insurance Company assigned identification number to identify our plan members. Risks associated with the use of an assigned identification number include the following: 1) the possibility exists that the assigned identification number may match another individual's Social Security Number or an assigned identfication number issued by another company; and 2) the use of an assigned identification number does not eliminate the possibility that another individual will access or misuse information related to that number.

I acknowledge and agree that coverage shall become effective only after (a) this signed Application has been accepted, and (b) a contract has been issued by Cigna Health and Life Insurance Company.

I AGREE ON BEHALF OF MYSELF AND AS AUTHORIZED AGENT OR REPRESENTATIVE OF MY ELIGIBLE DEPENDENTS TO THE PROVISIONS CONTAINED ON THIS FORM.

ARBITRATION

To the extent permitted by law, any controversy between Cigna Health and Life Insurance Company and an insured (including any legal representative acting on Your behalf), arising out of or in connection with this Policy may be submitted to arbitration upon written notice by one party to another. Such arbitration shall be governed by the provisions of the Commercial Arbitration Rules of the American Health Lawyers Association, to the extent that such provisions are not inconsistent with the provisions of this section.

If the parties cannot agree upon a single arbitrator within 30 days of the effective date of written notice of arbitration, each party shall choose one arbitrator within 15 working days after the expiration of such 30-day period and the two arbitrators so chosen shall choose a third arbitrator, who shall be an attorney duly licensed to practice law in the applicable state. If either party refuses or otherwise fails to choose an arbitrator within such 15-working-day-period, the arbitrator chosen shall choose a third arbitrator in accordance with these requirements.

The arbitration hearing shall be held within 30 days following appointment of the third arbitrator, unless otherwise agreed to by the parties. If either party refuses to or otherwise fails to participate in such arbitration hearing, such hearing shall proceed and shall be fully effective in accordance with this section, notwithstanding the absence of such party.

The arbitrator(s) shall render his (their) decision within 30 days after the termination of the arbitration hearing. To the extent permitted by law, the decision of the arbitrator, or the decision of any two arbitrators if there are three arbitrators, shall be conclusive of the controversy in question, and enforceable in any court of competent jurisdiction.

No party to this Policy shall have a right to cease performance of services or otherwise refuse to carry out its obligations under this Policy pending the outcome of arbitration in accordance with this section, except as otherwise specifically provided under this Policy.

You should be aware that North Carolina law in your state provides for judicial review of arbitration proceedings.

You should be aware and understand that you may be giving up certain rights to have your dispute settled in and by a court of law, unless the law in your state provides for judicial review of arbitration proceedings.

All applicants 18 years and older must sign and date application. Applicants under the age of 18 require custodial parent or legal guardian signature acknowledging their understanding of and agreement to the conditions listed above.

The above statements are true and complete to the best of my knowledge and belief. I understand and agree that for my child, and/or me and my eligible dependents, these statements shall be the basis for determination of acceptance for coverage under my applicable Cigna Health and Life Insurance Company benefit plan. I acknowledge and agree that any fraudulent misstatements or intentional omission of any applicant will render this contract null and void from its date of issue in accordance with applicable law. If my coverage is revoked I will receive written notice that will explain the decision and my right to appeal. I also understand that I will be required to pay for any services that were covered while a member and that Cigna Health and Life Insurance Company will refund all amounts paid by me except amounts owed to Cigna Health and Life Insurance Company.

Applicant Signature:	Today's Date: (MM/DD/YYYY)
Custodial Parent or Legal Guardian Signature (for applicants under the age of 18):	Today's Date: (MM/DD/YYYY)

Section M. Contact Information

Please return the application enrollment form to the broker or submit to the address listed below:

Cigna Health and Life Insurance Company Individual and Family Plans
P.O. Box 30362
Tampa, FL 33630-3362

FAX # 877.484.5927

www.Cigna.com

If you have questions about completing this application, please call Cigna Health and Life Insurance Company at 1.866.GET.Cigna (1.866.438.2446) 8:00 AM – 8:00 PM ET