Primary Applicant Name_____
Enrollment Form ID _____

Cigna Health and Life Insurance Company
Cigna HealthCare of Texas, Inc.
Texas Individual and Family Plan Enrollment Application / Change Form

Our PPO and EPO (Vantage) medical plans are only available in the following service areas/counties:

HOUSTON: Austin, Brazoria (partial county only), Brazos, Chambers (partial county only), Fort Bend, Galveston, Grimes, Harris, Liberty, Montgomery, San Jacinto (partial county only), Walker (partial county only), Waller, Washington

DALLAS: Collin, Cooke, Dallas, Denton, Ellis, Erath, Fannin, Grayson, Henderson, Hood, Hunt, Johnson, Kaufman, Navarro, Palo Pinto, Parker, Rockwall, Somervell, Tarrant, Wise

AUSTIN: Hays, Travis, Williamson

Our EPO (FocusIn) medical plans are only available in the following service areas/counties:

DALLAS: Collin, Dallas, Denton, Ellis, Rockwall and Tarrant counties

Our HMO medical plans are only available in the following service areas/counties:

HMO: Brazoria (partial county only), Harris (partial county only), Fort Bend (partial county only), Galveston (partial county only), Montgomery (partial county only) and Liberty(partial county only) counties

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/Cigna HealthCare of Texas, Inc. 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): _____

Primary Applicant Name_____ Enrollment Form ID _____

Section C. Benefit Plan Options

Select Desired Medical Benefit Plan:

HMO- Connect Plans
- ☐ Cigna Connect Flex Gold*
- ☐ Cigna Connect Flex Gold 1500*
- ☐ Cigna Connect Flex Silver 3000*
- ☐ Cigna Connect Flex Silver 4000*
- ☐ Cigna Connect Flex Silver 5000*
- ☐ Cigna Connect HSA Silver 2700*
- ☐ Cigna Connect Flex Bronze 6400*
- ☐ Cigna Connect HSA Bronze 6000*

PPO – (Houston)
- ☐ Cigna Health Flex 6400

EPO – Vantage Plans (Dallas-Austin)
- ☐ Cigna Vantage Flex Gold 1200
- ☐ Cigna Vantage Flex Silver 2750
- ☐ Cigna Vantage Flex Silver 5000
- ☐ Cigna Vantage HSA Silver 2700
- ☐ Cigna Vantage Flex Bronze 6400
- ☐ Cigna Vantage HSA Bronze 6000

EPO – Vantage Plans (Houston)
- ☐ Cigna Vantage Flex Gold 1000
- ☐ Cigna Vantage Flex Silver 2750
- ☐ Cigna Vantage Flex Silver 5000
- ☐ Cigna Vantage Flex Bronze 6400

:

EPO – FocusIn Plans
- ☐ Cigna FocusIn Flex Gold 1000
- ☐ Cigna FocusIn Flex Silver 2000
- ☐ Cigna FocusIn Flex Silver 4000
- ☐ Cigna FocusIn Flex Silver 5000
- ☐ Cigna FocusIn HSA Silver 2700
- ☐ Cigna FocusIn Flex Bronze 6400
- ☐ Cigna FocusIn HSA Bronze 6000

PPO – (Dallas-Austin)
- ☐ Cigna Health Flex 6400

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

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

You have the option to choose this Consumer Choice of Benefits Health Maintenance Organization health care plan that, either in whole or in part, does not provide state-mandated health benefits normally required in evidences of coverage in Texas. This standard health benefit plan may provide a more affordable health plan for you although, at the same time, it may provide you with fewer health plan benefits than those normally included as state-mandated health benefits in Texas. If you choose this standard health benefit plan, please consult with your insurance agent to discover which state-mandated health benefits are excluded in this evidence of coverage.

Section D. Applicant and Family Members

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. You may select an OB/Gyn for OB/Gyn services or you may use your PCP for those services. OB/Gyn Choice ID Number: _____

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 _____ Street _____ City State _____ ZIP Code	County	Home Phone Number: ( ) _____-_____ Cell Phone Number: ( ) _____-_____ Work Phone Number: ( ) _____-_____ Email Address:

Applicant's Language Preference. Should you have a condition affecting your ability to read or communicate, including a primary language other than English, you may contact Member Services at 1-800-CIGNA24 who will assist you. Please check one of the spoken and written language preferences below.

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 _____

Applicant's Spouse/Domestic Partner 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. You may select an OB/Gyn for OB/Gyn services or you may use your PCP for those services. OB/Gyn Choice ID Number: _____

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):
_____

Applicant's Spouse/Domestic Partner 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 children are covered up to age 26.
☐ Check here if you are providing names of additional dependents on an attached separate page.

Applicant's Dependent 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. You may select an OB/Gyn for OB/Gyn services or you may use your PCP for those services. OB/Gyn Choice ID Number: _____

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

Primary Applicant Name_____ Enrollment Form ID _____

Applicant's Dependent 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. You may select an OB/Gyn for OB/Gyn services or you may use your PCP for those services. OB/Gyn Choice ID Number: _____

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 the State of Texas 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/Cigna HealthCare of Texas, Inc. Use Only:	Effective Date:

Section E. Current Coverage and Additional Prior Coverage Information

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): _____

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 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. Please do not cancel other current health insurance coverage until written notification is received from Cigna Health and Life Insurance Company/Cigna HealthCare of Texas, Inc. indicating that your application has been approved, and you and your dependents are in receipt of your ID cards.

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/Cigna HealthCare of Texas, Inc.) 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:
☐☐☐☐-☐☐☐☐-☐☐☐☐-☐☐☐☐

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

Card Expiration Date:

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 can not 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. I verify that the applicant has received the required Outline of Coverage.

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/Cigna HealthCare of Texas, Inc. Sales Representative Last Name:		First Name:

Section K. Conditions and Agreement/Authorization

1. I understand that during the application process and after my enrollment, Cigna Health and Life Insurance Company/Cigna HealthCare of Texas, Inc. and other direct or indirect subsidiaries of Cigna Health and Life Insurance Company/Cigna HealthCare of Texas, Inc. may obtain and provide Confidential Information to others. For purposes of this Paragraph and Paragraph 2 and 3 below, "Confidential Information" means Payment Records, or Privileged Information; dental; disability; accident; or workers' compensation related information.
2. I authorize any insurance institution, employer, provider, insurance support organization, health care organization, and their agents and representatives to provide Confidential information on request by Cigna Health and Life Insurance Company/Cigna HealthCare of Texas, Inc. to representatives of Cigna Health and Life Insurance Company/Cigna HealthCare of Texas, Inc. who are authorized by Cigna Health and Life Insurance Company/Cigna HealthCare of Texas, Inc. to receive such information, to any Cigna Health and Life Insurance Company/Cigna HealthCare of Texas, Inc. participating provider, or to any other provider, person or entity performing a service for the following purposes: Plan administration, validating services and benefits payable under the Plan, performance of peer review, utilization management, quality assurance, grievance and appeals, care management, and/or to access the quality of or access to health care services and supplies. I further authorize Cigna Health and Life Insurance Company/Cigna HealthCare of Texas, Inc. (through its agents and representatives who are authorized by Cigna Health and Life Insurance Company/Cigna HealthCare of Texas, Inc. to disclose confidential information) to provide Confidential Information to the person or entities above when it determines that such disclosure is necessary or appropriate for the purpose specified in this paragraph or as otherwise authorized by applicable state or federal law, including the Health Insurance Portability and Accountability Act (HIPAA) Privacy Standards (45 C.F.R. Parts 160 and 164, Subpart E).

   I authorize Cigna Health and Life Insurance Company/Cigna HealthCare of Texas, Inc. to use such information and to disclose such information to affiliates, Providers, payors, other insurers, third party administrators, vendors, consultants, governmental authorities with jurisdiction when necessary for my care or treatment, payment for services, the operation of my health plan, or to conduct related activities.
3. I am providing authorization for myself and as agent or representation of my spouse and any dependent children. I understand that this authorization will remain in effect until I send written notice revoking it to Cigna Health and Life Insurance Company/Cigna HealthCare of Texas, Inc. or for such shorter period as required by law. I understand that to the extent this authorization applies to information collected in connection with this application for coverage, the authorization is valid for a period of thirty (30) months. I further understand that to the extent this authorization applies to information collected in connection with a claim for benefits under the Plan, the authorization is valid for and with respect to services received during the term of coverage under the Plan. Until revoked by me or by operation of law, this authorization remains in effect and may be relied on by Cigna Health and Life Insurance Company/Cigna HealthCare of Texas, Inc. and other parties.
4. I understand that any person who knowingly and with intent to defraud any insurance company or other person files 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 fraudulent insurance act and may be subject to civil and criminal penalties.
5. I authorize that payment be made under Part B of Medicare to Cigna Health and Life Insurance Company/Cigna HealthCare of Texas, Inc. for medical and other services furnished by Cigna Health and Life Insurance Company/Cigna HealthCare of Texas, Inc. for which it pays or has paid, if applicable.
6. I agree that in the event health services provided or covered are the primary responsibility of a third party as a result of a personal injury to the covered individual, I will fully inform Cigna Health and Life Insurance Company/Cigna HealthCare of Texas, Inc. and execute such documents and provide such assistance as may be necessary to enable Cigna Health and Life Insurance Company/Cigna HealthCare of Texas, Inc. to recover the value of services provided, arranged or covered. When I'm not represented by an attorney in obtaining a recovery, Cigna Health and Life Insurance Company/Cigna HealthCare of Texas, Inc. is entitled to recover a share of my recovery amount that is equal to the lesser of: 1) one-half of my gross recovery; or 2) the total cost of benefits paid as a direct result of the third party's conduct. When I am represented by an attorney in obtaining a recovery, Cigna Health and Life Insurance Company/Cigna HealthCare of Texas, Inc. is entitled to recover a share of my recovery amount that is equal to the lesser of: 1) one-half of my gross recovery less attorney's fees and procurement costs; or 2) the total cost of benefits paid as a direct result of the third party's act less attorney's fees and procurement costs. The total attorney's fees may not exceed one-third of Cigna Health and Life Insurance Company's/Cigna HealthCare of Texas, Inc.'s recovery. Cigna Health and Life Insurance Company/Cigna HealthCare of Texas, Inc. may pursue recovery against uninsured/underinsured motorist coverage or medical payments coverage only if the covered individual or the covered individual's immediate family did not pay the premiums for the coverage.
7. I understand that I or my authorized representative is entitled to receive a copy of this authorization form.
8. I understand that information disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and will no longer be protected by federal privacy regulations.
9. I acknowledge that I have received an outline of coverage.
10. 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/Cigna HealthCare of Texas, Inc. will issue a Cigna Health and Life Insurance Company/Cigna HealthCare of Texas, Inc. 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 identification number issued by another company; and 2) use of an assigned identification number does not eliminate the possibility that another individual will access or misuse information related to that number.

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

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/ Cigna HealthCare of Texas, Inc. benefit plan. I acknowledge and agree that any misrepresentation 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/Cigna HealthCare of Texas, Inc. will refund all amounts paid by me except amounts owed to Cigna Health and Life Insurance Company/Cigna HealthCare of Texas, Inc..

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 L. 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/Cigna HealthCare of Texas, Inc. within 30 days from the signature date.
- 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/Cigna HealthCare of Texas, Inc.
- 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 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/Cigna HealthCare of Texas, Inc. Individual and Family Plans
P.O. Box 30362
Tampa, FL 33630-3362
FAX # 1.877.484.5927

www.cigna.com

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

Section N. Notice to Applicant Regarding Replacement of Accident and Sickness Insurance

According to (your application, you intend to lapse or otherwise terminate existing accident and sickness insurance and replace it with a policy to be issued by Cigna Health and Life Insurance Company/Cigna HealthCare of Texas, Inc. For your own information and protection, you should be aware of and seriously consider certain facts which may affect the insurance protection available to you under the new policy.

(1) You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interests to make sure you understand all the relevant factors involved in replacing your present coverage.

(2) If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical/health history. Failure to include all material medical information on any application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, re-read it carefully to be certain that all information has been properly recorded.

The above "Notice to Applicant" was delivered to me on: _____

Primary Applicant Signature:	Today's Date: (MM/DD/YYYY)