Primary Applicant Name _____

Enrollment Form ID _____

Cigna Health and Life Insurance Company/CHLIC
Cigna HealthCare of Arizona, Inc./CHCAZ
Arizona Individual Enrollment Application / Change Form

Section A. Type of Application

New Enrollment Application:

☐ Applicant Only ☐ Applicant and Dependent(s) ☐ *Child Only

*Must complete one application for each child. Applications containing multiple children will not be accepted.

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 Arizona, 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 without a qualifying life event which allows same day coverage.*

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:

Non-HMO: ☐ Cigna Access 6000 CHLIC

HMO:

CHCAZ ☐ Cigna Connect 6400*

Select Desired Dental Benefit Plan: CHLIC

☐ Cigna Dental Preventive

☐ 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

To meet the Affordable Care Act requirements, Cigna Health and Life Insurance Company/Cigna HealthCare of Arizona, Inc. Individual and Family medical plans that are not sold through the federal marketplace also include a pediatric dental policy for children under the age of 19.

Primary Applicant Name _____ Enrollment Form ID _____

Section D. Applicant, Spouse and Dependent Information

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

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

Is any applicant enrolled in Medicare? ☐ Yes ☐ No

If you answered "Yes" to the above question, provide names of Medicare enrollees:

_____

For these applicants, please stop here, they are not eligible to enroll in health coverage.

Is any applicant eligible for Medicare? ☐ Yes ☐ No

If you answered "Yes" to the above question, provide names of individual(s) eligible for Medicare:

_____

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

Mailing Address – Home Address Required
Street
City County State
ZIP Code (Please provide 9-digit ZIP Code)

Billing Address – If different than mailing address
P.O. Box / Street
City State
ZIP Code

Home Phone Number: ( ) —
Cell Phone Number: ( ) —
Work Phone Number: ( ) —
E-Mail 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

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

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

Is any applicant enrolled in Medicare? ☐ Yes ☐ No

If you answered "Yes" to the above question, provide names of Medicare enrollees:

_____

For these applicants, please stop here, they are not eligible to enroll in health coverage.

Is any applicant eligible for Medicare? ☐ Yes ☐ No

If you answered "Yes" to the above question, provide names of individual(s) eligible for Medicare:

_____

Primary Applicant Name _____ Enrollment Form ID _____

Applicant's Spouse/Domestic Partner/Civil Union 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.	Social Security Number: iTIN:

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

Is there a Qualified Medical Child Support Order (*QMCSO)? ☐ Yes ☐ No

*A medical child support order which creates or recognizes the existence of a child's right to receive medical benefits which the responsible parent is eligible for under a health plan.

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

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

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

Is there a Qualified Medical Child Support Order (*QMCSO)? ☐ Yes ☐ No

*A medical child support order which creates or recognizes the existence of a child's right to receive medical benefits which the responsible parent is eligible for under a health plan.

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

Primary Applicant Name _____ Enrollment Form ID _____

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. Do all enrollees reside within Arizona 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 Arizona, Inc. 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 (MM/DD/YYYY): _____

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 (MM/DD/YYYY): _____

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 Arizona, Inc. indicating that your application has been approved, and you and your dependents are in receipt of your ID cards.

Primary Applicant Name _____ Enrollment Form ID _____

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.

Initial Premium Payment Method: ☐ Use this account for my initial and subsequent premium payments.

Account Number: _____ ☐ Checking ☐ Saving

Routing Number: ☐☐☐☐☐☐☐☐☐

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

For Subsequent premium payment (If you desire to use a different bank account):

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 Arizona, 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: 3-digit Code: Card Expiration Date:

☐☐☐☐ — ☐☐☐☐ — ☐☐☐☐ — ☐☐☐☐ ☐☐☐

Account Holder's ZIP 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.

Primary Applicant Name _____ Enrollment Form ID _____

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:	National Producer Number:
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.		
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 Arizona, Inc. 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/Cigna HealthCare of Arizona, 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 Arizona, 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.

Primary Applicant Name _____ Enrollment Form ID _____

Section L. Conditions and Agreement/Authorization

1. OAP and HSP applicants: I understand that under the Cigna Health and Life Insurance Company/Cigna HealthCare of Arizona, Inc. plan in which I am enrolling, I will be entitled to lesser benefits if I use an out-of-network hospital, physician or other healthcare facility.
2. I understand that during the application process and after my enrollment, direct or indirect subsidiaries of Cigna Health and Life Insurance Company/Cigna HealthCare of Arizona, Inc. may obtain and provide Confidential Information to others. For purposes of this Paragraph and Paragraph 3 and 4 below, "Confidential Information" means Medical Record Information, Payment Records, Protected Health Information and/or Privileged Information as defined by applicable law; dental; disability; accident; or workers' compensation related information, and expressly includes the following: CONFIDENTIAL HIV-RELATED INFORMATION (AS DEFINED IN A.R.S. § 20-448.01), CONFIDENTIAL COMMUNICABLE DISEASE-RELATED INFORMATION (AS DEFINED IN A.R.S.§ 20-448.02), CONFIDENTIAL ALCOHOL OR DRUG ABUSE TREATMENT OR RELATED INFORMATION (AS DEFINED IN 42 C.F.R.S 2.1 ET SEC.), CONFIDENTIAL MENTAL HEALTH DIAGNOSIS/TREATMENT INFORMATION, CONFIDENTIAL PSYCHOTHERAPY NOTES (AS DEFINED IN 42 C.F.R. S 164.501), AND CONFIDENTIAL GENETIC TESTING INFORMATION (AS DEFINED IN A.R.S. § 20-448.02).
3. 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 Arizona, Inc. to representatives of Cigna Health and Life Insurance Company/Cigna HealthCare of Arizona, Inc. who are authorized by Cigna Health and Life Insurance Company/Cigna HealthCare of Arizona, Inc. to receive such information, to any Cigna Health and Life Insurance Company/Cigna HealthCare of Arizona, 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 Arizona, Inc. (through its agents and representatives who are authorized by Cigna Health and Life Insurance Company/Cigna HealthCare of Arizona, 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 understand confidential HIV-related information will be disclosed only in accordance with A.R.S. §20-448.01 (C) and will not be released without a separate signed patient authorization.

   I authorize Cigna Health and Life Insurance Company/Cigna HealthCare of Arizona, Inc.a to request my and/or my dependents' (those who are applying for coverage under this enrollment form) medical records, any prescribed medication history, and any other medical or pharmaceutical information to administer claims and determine or fulfill responsibility for coverage and provisions of benefits; 3) administer coverage; and 4) conduct other insurance operations according to federal and state laws and regulations.

   I authorize Cigna Health and Life Insurance Company/Cigna HealthCare of Arizona, 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.
4. 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 Arizona, 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 from the date the application is signed. 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 Arizona, Inc. and other parties.
5. I understand that A.R.S. §20-458 provides that any person who knowingly makes a false or fraudulent statement or representation in or relative to an application for disability insurance, or who makes any such statement to obtain a benefit, is guilty of a class 2 misdemeanor.
6. I authorize that payment be made under Part B of Medicare to Cigna Health and Life Insurance Company/Cigna HealthCare of Arizona, Inc. for medical and other services furnished by Cigna Health and Life Insurance Company/Cigna HealthCare of Arizona, Inc. for which it pays or has paid, if applicable.
7. I agree that in the event health services provided or covered are the primary responsibility of Medicare, workers' compensation coverage, automobile medical payment coverage, or other payments source Cigna Health and Life Insurance Company/Cigna HealthCare of Arizona, Inc. may be authorized by applicable law to pursue, to fully inform Cigna Health and Life Insurance Company/Cigna HealthCare of Arizona, Inc. and execute such documents and provide such assistance as may be necessary to enable Cigna Health and Life Insurance Company/Cigna HealthCare of Arizona, Inc. to recover the value of services provided, arranged or covered.
8. I understand that I or my authorized representative is entitled to receive a copy of this authorization form.
9. 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.
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).

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/Cigna HealthCare of Arizona, Inc.

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

Primary Applicant Name _____ Enrollment Form ID _____

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

Applicant Signature	Today's Date (MM/DD/YYYY)	Applicant Spouse's/Domestic Partner/Civil Union Signature	Today's Date (MM/DD/YYYY)

Applicant's Dependent Age 18 or Older	Today's Date (MM/DD/YYYY)	Applicant's Dependent Age 18 or Older	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/Cigna HealthCare of Arizona, Inc. Individual and Family Plans
P.O. Box 30362
Tampa, FL 33630-3362
FAX # 877.484.5927
www.Cigna.com

Section N. Attestation Regarding Pediatric Dental Coverage (For applicants and dependents under the age of 19)

If you, for yourself or on behalf of your eligible dependent(s), accept an offer of medical coverage under any of the health plans noted on page 1 of this form, you must sign and attest to the following:

I am accepting coverage of a Cigna Health and Life Insurance Company (Non-HMO) or Cigna HealthCare of Arizona, Inc. (HMO) health benefit plan, and a pediatric dental benefit plan provided by Cigna Health and Life Insurance Company for applicants and dependents under the age of 19. I understand that pediatric dental coverage is an essential health benefit that insurers are required to provide under the Affordable Care Act. In order to obtain a health benefit plan (which excludes pediatric dental benefits) please proceed to www.Healthcare.gov or call 877-484-5966.

If you want to only obtain a health benefit plan without also purchasing a pediatric dental benefit plan, please proceed to www.Healthcare.gov to purchase an On Marketplace health benefit plan or call Cigna at 877-484-5966.

Signature: _____ Date: (MM/DD/YYYY): _____

