Please return BOTH pages to:

Cigna Medicare Services
Attn: Enrollment & Eligibility
25500 N. Norterra Drive
Phoenix, AZ 85085
FAX: 844-224-6952

Dental Benefit Change Election Form

Date of Request: ___________________
Effective Date of Change: ____________________
Cigna Customer ID# ____________________

Name: _____________________________ Phone: (___) _________
Permanent Address:
____
City: ______________________State: ___________ Zip Code: ___________

_____ I would like to **ADD** the optional DENTAL benefit to my Plan for a premium of $13.50 a month.

_____ I would like to **DROP** the optional DENTAL benefit from my Plan.

Have you recently **moved** into this plan's service area? Yes _____ No _____

Have you **changed** your Medicare coverage in the past 6 months? Yes _____ No ______

Your Plan Premium Option
You can have the monthly premium for this Medicare plan automatically deducted from your Social Security check. If you don't choose this option, we will send you a premium coupon book which you can pay by mail or you can sign up for our Electronic Funds Transfer option. Generally you must stay with the option you choose for the rest of the year. If you qualify for extra help with your Medicare prescription drug coverage costs, Medicare may cover all or some portion of your plan premium. Please choose if you want the remaining premium, if there is any, deducted from your monthly check. **Would you like the premium for this plan deducted from your monthly SSA benefit check? □ Yes □ No**

Please Read and Sign Below:

Release of Information: By joining this Medicare health plan, I acknowledge that the Medicare health plan will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. The information on this enrollment form is correct to the best of my knowledge. I understand that if I intentionally provide false information on this form, I will be disenrolled from the plan.

I understand that beginning on the date Cigna Medicare coverage begins, I must get all my health care from Cigna Medicare with the exception of emergency or urgently needed services or out-of-area dialysis services. Medicare beneficiaries are generally not covered under Medicare while out of the country except for limited coverage in Canada and Mexico. Services authorized by Cigna Medicare and other services contained in my Plan Evidence of Coverage document will be covered. Without authorization, **NEITHER MEDICARE NOR CIGNA WILL PAY FOR THE SERVICES.**

I understand that my signature (or the signature of the person authorized to act on behalf of the individual under the laws of the State where the individual resides) on this application means that I have read and understand the contents of this application. If signed by an authorized individual (as described above), this signature certifies that: 1) this person is authorized under State law to complete this enrollment and 2) documentation of this authority is available upon request by Plan or by Medicare.

Your Signature:	**Today's Date:**

If you are the authorized representative, you must provide the following information:
Name: ____
Address: ____
Phone Number : (______) __________-________________
Relationship to Enrollee ___________________________

The effective date of this change will be the first of the month following the receipt of this completed form in the Cigna Medicare Services Enrollment & Eligibility Department of Cigna HealthCare of Arizona, Inc.

If you have questions regarding your benefits, please call our Customer Service Department at 1-800-627-7534 (TTY: 711). We are open October 1 through March 31: 7 days a week from 8am until 8pm. April 1 through September 30: Monday-Friday from 8am until 8pm. (voice response system is available on weekends and holidays).

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