Arizona Employee Enrollment/Change of Coverage Form

(for groups with 2-50 employees)

Employee Social Security Number:
Group Number: *(Existing Cigna member)*

Instructions: You, the employee, must complete this enrollment form in full to avoid a delay in processing. You are solely responsible for its accuracy and completeness. **If waiving coverage, please enter your name, address and company name in Section 1 and complete Section 4 only.**

SECTION 1 – Employee/Employer Information

Employee Name:	Employer Name / Location:	Date of Hire:
Employee Address: Street City State ZIP Code (9-digit) County	Employee Mailing Address:] Street City State ZIP Code) County	Home Phone No. Work Phone No:

Employment Status:	Job Title:	# Hours Worked Per Week:	# Enrolling (including self):	Marital Status:	Proposed Effective Date:
☐ Full-Time ☐ 1099 ☐ Other ☐ Part-Time ☐ Seasonal _____				☐ Married ☐ Single	

Reason for Application:		COBRA Original Qualifying Event Date:
☐ New Group Enrollment ☐ New Hire ☐ Late Enrollee ☐ Change of Coverage (existing insured only)	☐ Rehire ☐ Change of Address ☐ Name Change Only ☐ Add Dependents (Spouse/Dependent Child) ☐ COBRA	Reason: Length of Continuation: ☐ 18 months ☐ 36 months ☐ Other ____months

SECTION 2 – Plan Selection – Please indicate the plan and option your employer offers in which you are enrolling.

Note: You can only enroll in a plan your employer has selected to offer your group.

[Health Savings Plans]	[HMO Plans]
[☐ HealthSavings Plan]	[☐ Health Flex HMO]

SECTION 3 – Complete for All Individuals to Be Covered (dependent children are covered to age 26)

Last Name	First Name	Sex M/F	Social Security Number	Date of Birth mm/dd/yyyy	Disabled	Name of Primary Care Physician (PCP) required for [HMO, optional for OAP] plans	Current Patient?
Self:							☐ Yes
Spouse:							☐ Yes
Child:					☐ Yes		☐ Yes
Child:					☐ Yes		☐ Yes
Child:					☐ Yes		☐ Yes

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:

SECTION 4 – Waiver of Coverage – Only complete if waiving coverage for any reason.

I understand that I am eligible for coverage being offered. However, I and/or the dependents listed below voluntarily waive the coverage. If coverage is waived, I am also stating the reasons why I/we are waiving coverage. (Please list names and indicate reasons below.)		
☐ Employee	☐ Med	**Reason for waiving coverage:** ☐ Covered by Spouse's group coverage Provide Carrier Name and proof of other coverage _____ ☐ Enrolled in other Non-Group coverage: ☐ Medicare ☐ Retiree ☐ Military ☐ COBRA ☐ State Continuation ☐ Individual Private Insurance ☐ Other, list other Insurance Company Name _____ ☐ Other Reason for waiving coverage _____
☐ Spouse	☐ Med	
☐ Child(ren):	☐ Med	
By waiving this coverage, I acknowledge that myself and/or dependent(s) may have to wait to enroll until the plan's next renewal date. Waiting periods and limitations may apply at the time of a future enrollment.		
Sign here only if you are waiving coverage for yourself and/or dependents:		Date:

SECTION 5 – Other Coverage – Non completion of this section and failure to provide Proof of Prior Coverage may subject you and/or an enrolling family member to Waiting Periods and Limitations.

Does anyone enrolling on this form have current or prior coverage? ☐ Yes ☐ No If answered "Yes", complete section below and provide Proof of Prior Coverage.

Name	Prior or Current Insurance Company Name	Start Date	End Date	Currently On Medicare: ☐ Yes ☐ No If under age 65 and answered yes, please indicate reason.	List which part of Medicare (Parts A, B, D)

SECTION 6 – Dependent Information

☐ Does any dependent listed in Section 3 live at another address? ☐ Yes ☐ No

If answered "Yes", who and at what address _____.

☐ If any dependent's last name differs from yours, explain the circumstances _____.

SECTION 7 – Authorization

n **Acknowledgment of key terms.** In completing this Application, I agree to the following for my self and all eligible dependents:

1. That any hospital, physician or other provider may furnish Cigna medical information that may be required to conduct a utilization review program of health services, and to coordinate benefits and/or reimbursements with other health or insurance programs.
2. That all information furnished by me is true and complete to the best of my knowledge.
3. That any person who knowingly and with intent to defraud Cigna or any 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 a fraudulent insurance act and may be subject to civil and criminal penalties.
4. That my employer's application will determine coverage and that I will not receive coverage until both this application and the employer's application have been accepted and approved by Cigna.
5. That should I and my dependents be issued coverage, any dispute or claim shall be resolved according the grievance procedures contained in the Certificate of Coverage issued by Cigna to enrollees.
6. That should I or my dependents be issued coverage and Cigna provides health services that are the primary responsibility of Medicare, workers' compensation coverage, automobile medical payment coverage, or other payments source Cigna may be authorized by law to pursue, we shall inform Cigna of the other source of payment and execute such documents and provide such assistance as may be necessary to enable Cigna to recover the value of services provided, arranged or covered.

7. That I am entitled upon request to a copy of this application, including the authorizations and acknowledgements made by me herein.
8. If a social security number is not provided on this application, Cigna will issue a Cigna assigned identification number to identify our plan members. Risks associated with the use of an assigned identification number include the following:
   a. 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.
   b. Use of an assigned identification number does not eliminate the possibility that another individual will access or misuse information related to that number.
9. I understand that this authorization will remain in effect until I send written notice revoking it to Cigna 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 and other parties.

Employee Signature:	Today's Date:

- Please keep a copy of this application for your records.
- NOTE: If there are any modifications to the statements and responses provided in this application (i.e. crossed out, white-out, erased information), the applicant must attest to the modifications by providing a complete signature in the margin near the modification.