Arizona
Small Group Employer Application
(for groups with 2-50 eligible employees)

☐ New Policy ☐ Change in Policy/Type of Change _____	Requested Effective Date:

1. Employer Information

Employer Name or DBA (doing business as)			Date Business Established	SIC Code:
Company Contact Person	Phone Number	Fax Number	Fed Tax ID Number	
Street Address	City	State	ZIP Code	
Billing Address	City	State	Zip Code	
Email Address:	Type of Employer: ☐ Corporation ☐ Sole Proprietor ☐ Partnership ☐ Non-Profit ☐ Other _____			
Has the company been insured by Cigna or one of its affiliates in the last 24 months? ☐ Yes ☐ No If answered "Yes," please provide the following: Name previously insured under _____ Account Number _____ Term Date _____				
Does the company file State or Federal taxes with another company on a consolidated basis? ☐ Yes ☐ No If you answered "Yes," please explain:				

2. Plan Options

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

3. Employee Information

Total No. of employees in the company: (incl. part-time, 1099s, seasonal, etc.)	Total No. of eligible employees:	Total No. of employees enrolling in coverage:	Total No. of eligible employees waiving coverage:
Of the employees waiving, how many have "other" group coverage?	Of the employees waiving, how many have no coverage elsewhere?	Total No of Ineligible employees: (such as part-time, 1099s, seasonal, Other _____)	
Number of hours an employee needs to work per week in order to be considered eligible for benefits? _____			
Do you wish to cover 1099s (Independent Contractors)? ☐ Yes ☐ No Total No. Enrolling _____	What percentage of your employees are 1099s?		
Do you wish to waive the waiting period for existing employees? ☐ Yes ☐ No			
Benefit Waiting Period for new employees will be: _____days (not to exceed 90 days, coverage may not become effective beyond the 90th day after date of hire)			

4. COBRA/State Continuation/Tefra/Defra/Medicare/ERISA

Is your group subject to COBRA?*	☐ Yes ☐ No
For actively working employees over 65, will Cigna be Primary or Secondary to Medicare?**	☐ Primary ☐ Secondary
Is your group subject to ERISA?*** ☐ Yes ☐ No If yes, ERISA Code:_____	
Does the group have a flex plan under Section 125 of the IRS Code?	☐ Yes ☐ No

* Your group will be subject to COBRA if you employed 20 or more employees during at least 50% of the working days in the previous calendar year.

** Under Tefra/Defra, **Cigna** will be the **primary** coverage for employees and their spouses who are age 65 or older if the employer has 20 or more employees for each working day in each of the 20 or more calendar weeks in the current or preceding calendar year. **Medicare** is the **primary** coverage for such employees if the employer has less than 20 employees for each working day in each of the 20 or more calendar weeks in the current or preceding calendar year.

*** All employer groups EXCEPT church groups and governmental entities are subject to ERISA regardless of the number of employees.

5. COBRA – List all current COBRA participants and terminated employees who have not yet elected COBRA.

Name:	☐ Currently on Continuation ☐ In Continuation Election Period But Not Yet Elected	Reason:	Continuation Dates Orig Start / End
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If more room is needed, please attach a separate page to this application.

6. Employer Contribution

Employer contribution* to Employee Medical _____% or $_____
Employer contribution to Dependent Medical _____% or $_____

**Employer must contribute at least 50% toward employee's Medical coverage.*

NOTE: Contribution toward dependent coverage is not required.

7. Current or Prior Coverage Information

Will coverage be transferring from another carrier? ☐ Yes ☐ No	Name of Current or Prior Carrier:	Total Replacement? ☐ Yes ☐ No
Prior or Current Coverage* Type ☐ Medical ☐ Dental ☐ Life	Prior or Current Carrier Effective Date: _____	Prior or Current Carrier proposed Termination Date: _____

Do not cancel Existing coverage until written notification of coverage approval has been received by Cigna.

8. Workers' Compensation Information

Does your group carry Workers' Compensation coverage?	☐ Yes ☐ No
Name of Workers' Compensation carrier:	Effective Date: _____ Renewal Date: _____
Are all employees covered by Workers' Compensation coverage?	☐ Yes ☐ No
If not all employees are covered, please indicate who is not covered and why:	

[9. Payment Method

Initial Payment: (Please select one option only) Please submit with your application a business check for initial payment made payable to Cigna attached to this completed form.
Ongoing Payment Options:: ☐ Yes, I agree to submitting a Business check monthly with payment voucher.

10. Authorization

Company Representative Signature:	Title of Company Representative:	
Company Representative Printed Name:	Location (City, State):	Date Signed:

- 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.

11. Broker/Agent

I Certify: n To the best of my knowledge, the information provided by my client is accurate and complete, and no information has been omitted that has bearing on this risk. n I have advised the client not to terminate any existing coverage until receiving written notice from Cigna that coverage applied for by this application has been accepted.			
Broker/Agent Name:		Tax ID/SSN:	Email Address:
Brokerage/Agency Name:			
Address:		Phone:	Fax:
Signature:	Date:	Tax ID Payable To:	Comp. Split %:
Broker/Agent Name:		Tax ID/SSN:	E-mail Address:
Brokerage/Agency Name:			
Address:		Phone:	Fax:
Signature:	Date:	Tax ID Payable To:	Comp. Split %:
General Agent Name:		General Agent TIN:	General Agent Phone:
Address:		General Agent Fax:	Email Address:
Signature:			Date:

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