Cigna Dental Enrollment Form

Employer: Complete Section A
Employee: Complete Sections B, C & D

Cigna HealthCare of Connecticut, Inc.
Cigna Health and Life Insurance Company

Please print and thank you for providing this information

A

☐ OPEN ENROLL. ☐ CHANGE ☐ NEW ENROLL. ☐ REINSTATE	EFFECTIVE DATE OF ADD/CHANGE/ CANCELLATION (MM/DD/CCYY)	EMPLOYER NAME		EMPLOYER ADDRESS		
CIGNA ACCOUNT NO.	DIVISION/BRANCH/LOCATION/CLASS	DATE OF HIRE (MM/DD/CCYY)	NETWORK ID	BRANCH CODE	CDH GROUP NO.	DENTAL BENEFIT OPTION

TYPE OF CHANGE:

- ☐ **Add Dependent(s) *** Date: ____________________
- ☐ **Cancel Employee** Last Date of Coverage: ____________________
- ☐ **Cancel Dependent(s) *** Last Date of Coverage: ____________________
  - Reason for Cancellation:
    - ☐ Leave employment
    - ☐ Transfer out of Cigna Dental Care area
    - ☐ Transfer to another plan
- ☐ **Address Change**
- ☐ **Transfer to COBRA**
  - ☐ 18 mos. ☐ 29 mos. ☐ 36 mos.
- ☐ **Other**____________________

*** List Names in Section C**

B

EMPLOYEE NAME *(Last)*	*(First)*	*(M.I.)*	SOCIAL SECURITY NO.

EMPLOYEE DATE OF BIRTH (MM/DD/CCYY)	HOME PHONE	WORK PHONE	HOME E-MAIL ADDRESS	EMPLOYEE IDENTIFICATION NUMBER
	( )	( )		

ADDRESS *(Street)*	*(City)*	*(State)*	*(Zip Code)*

WHAT IS YOUR PRIMARY LANGUAGE? *(optional)*	DO YOU HAVE A DISABILITY AFFECTING YOUR ABILITY TO COMMUNICATE OR READ? *(optional)*	SELECT PLAN:
	☐ Yes ☐ No	☐ Cigna Dental Care® ☐ Cigna Traditional ☐ Cigna Dental PPO

C

I WOULD LIKE COVERAGE FOR ME AND MY DEPENDENTS. *(Specify last name if different from yours)* Last Name / First Name / M.I.	DEPENDENT SOCIAL SECURITY NO.	DATE OF BIRTH MM DD CCYY	GENDER	FULL-TIME STUDENT? Yes / No	DENTAL OFFICE SELECTION *(for Cigna Dental Care only)*	START DATE OF CONTINUOUS DENTAL COVERAGE *(for Cigna Dental PPO only)* *(Month, Day, Year)*	*(check one)*
Employee			☐ M ☐ F		1st Choice - 2nd Choice -		☐ Add ☐ Cancel
Spouse			☐ M ☐ F		1st Choice - 2nd Choice -		☐ Add ☐ Cancel
Dependent / Relationship			☐ M ☐ F	☐ ☐	1st Choice - 2nd Choice -		☐ Add ☐ Cancel
Dependent / Relationship			☐ M ☐ F	☐ ☐	1st Choice - 2nd Choice -		☐ Add ☐ Cancel
Dependent / Relationship			☐ M ☐ F	☐ ☐	1st Choice - 2nd Choice -		☐ Add ☐ Cancel

Proof of student or handicapped status for overage dependents may be required.
The original effective date must be completed for each member in order for continuous coverage credit to be applied toward waiting period.

D

SIGNATURE - The information provided above is true and correct to the best of my knowledge, and I accept the provisions on the reverse side of this form which I have read and understand.

EMPLOYEE'S SIGNATURE / DATE

NOTE: Not all products are available for all clients or all states. Check your enrollment materials carefully to see what is offered for your group.

DISTRIBUTION: **White -** Cigna **Canary -** Member **Pink -** Employer

PROVISIONS

- In Connecticut, the Cigna Dental Care (DHMO) product is provided through Cigna HealthCare of Connecticut, Inc. The Cigna Dental PPO plan is underwritten or administered by Cigna Health and Life Insurance Company with network management services provided by Cigna Dental Health, Inc. and certain of its operating subsidiaries. The Cigna Traditional (Indemnity) plan is underwritten and/or administered by Cigna Health and Life Insurance Company.
- I accept the coverage/insurance benefits provided by this group plan and authorize the processing of my enrollment in the coverage as indicated on this form. I authorize deduction from my earnings of the required contributions, if any, toward the cost of the coverage.
- I authorize payment of benefits to the participating provider.
- I authorize any participating office to release records and billing information concerning me or my covered dependents to Cigna HealthCare of Connecticut, Inc., Cigna Dental Health, Inc. and Cigna Health and Life Insurance Company for purposes of plan administration or for the purpose of validating and determining benefits payable. I further authorize Cigna HealthCare of Connecticut, Inc., Cigna Dental Health, Inc. and Cigna Health and Life Insurance Company to release any records or information concerning me or my covered dependents to its designee, for purposes of plan administration and customer service.

AUTHORIZATION TO DISCLOSE CONFIDENTIAL INFORMATION AND FRAUD NOTICE

- I understand that after I enroll, Cigna may need to obtain Confidential Information. I also understand that Cigna may need to provide this Confidential Information to others. Any person or entity having Confidential Information has my permission to provide this Confidential Information upon request to Cigna, any Cigna participating provider, or any other provider or entity performing a service for the purpose of plan administration, the performance of any Cigna program or operations, or to assess the quality of and access to health care services and supplies. Cigna has my permission to give any Confidential Information to any person, company or entity when it determines that such disclosure is necessary or appropriate for the administration of the plan, the performance of Cigna programs or operations, assessing quality and accessibility of health care services and supplies, or reporting to third parties involved in plan administration. I am making this authorization for myself and as the agent or representative of my covered spouse and any covered dependent children (if applicable). I understand that it will remain in effect until I send written notice revoking it to Cigna or for such shorter period as required by law. Until revoked, this authorization may be relied upon by Cigna and other parties. "Confidential Information" means, with respect to me and any covered dependents, any medical, dental, mental health, substance abuse, communicable disease, AIDS and HIV related information and disability or employment related information. Cigna means the Cigna companies involved in the administration of the plan, including but not limited to Cigna Health and Life Insurance Company, Cigna HealthCare of Connecticut, Inc., and Cigna Dental Health, Inc. and its subsidiaries.

- Any person who, knowingly and with intent to defraud any insurance company or other person: (1) files an application for insurance or statement of claim containing any materially false information; or (2) conceals for the purpose of misleading, information concerning any material fact thereto, commits a fraudulent insurance act.

"Cigna" and "Cigna Dental Care" are registered service marks, and the “Tree of Life” logo is a service mark, of Cigna Intellectual Property, Inc., licensed for use by Cigna Corporation and its operating subsidiaries. All products and services are provided by or through such operating subsidiaries and not by Cigna Corporation. Such operating subsidiaries include Cigna Health and Life Insurance Company, Cigna HealthCare of Connecticut, Inc., and Cigna Dental Health, Inc. and its subsidiaries.

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