Cigna Dental Enrollment Form

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

Insured and/or Administered by
Cigna Health and Life Insurance Company

Cigna

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
		City of Medford	85 George P. Hassett Drive, Medford, MA 02155

CIGNA ACCOUNT NO.	DATE OF HIRE (MM/DD/CCYY)	BRANCH CODE	DENTAL BENEFIT OPTION
3342720			☐ DPPO High ☐ DPPO Base

B

TYPE OF CHANGE:

- ☐ **New Enrollment*** Date: _____ ☐ Address Change
- ☐ **Add Dependent(s) *** Date: _____
- ☐ **Cancel Employee** Last Date of Coverage: _____
- ☐ **Cancel Dependent(s) *** Last Date of Coverage: _____

Reason for Cancellation: ☐ Leave employment

*** List Names in Section D**

C

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)*

SELECT PLAN:

☐ Cigna Dental PPO High ☐ Cigna Dental PPO Base ☐ Decline Coverage

D

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	*(check one)*
Employee			☐ M ☐ F	☐ Add ☐ Cancel
Spouse			☐ M ☐ F	☐ Add ☐ Cancel
Dependent — Relationship			☐ M ☐ F	☐ Add ☐ Cancel
Dependent — Relationship			☐ M ☐ F	☐ Add ☐ Cancel
Dependent — Relationship			☐ M ☐ F	☐ 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.

E

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.

PROVISIONS

- The Cigna Dental Care (DHMO) plan is underwritten or administered by Cigna Dental Health Plan of Arizona, Inc., Cigna Dental Health of California, Inc., Cigna Dental Health of Colorado, Inc., Cigna Dental Health of Delaware, Inc., Cigna Dental Health of Florida, Inc., a Prepaid Limited Health Services Organization licensed under Chapter 636, Florida Statutes, Cigna Dental Health of Kansas, Inc. (Kansas and Nebraska), Cigna Dental Health of Kentucky, Inc. (Kentucky and Illinois), Cigna Dental Health of Maryland, Inc., Cigna Dental Health of Missouri, Inc., Cigna Dental Health of New Jersey, Inc., Cigna Dental Health of North Carolina, Inc., Cigna Dental Health of Ohio, Inc., Cigna Dental Health of Pennsylvania, Inc., Cigna Dental Health of Texas, Inc., and Cigna Dental Health of Virginia, Inc. In other states, the Cigna Dental Care plan is underwritten by Cigna Health and Life Insurance Company or Cigna HealthCare of Connecticut, Inc. and administered by Cigna Dental Health, Inc.
- The term "DHMO" is used to refer to product designs that may differ by state of residence of enrollee, including but not limited to prepaid plans, managed care plans and plans with open access features.
- The Cigna Dental PPO and EPO plans are 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 (Dental Indemnity) and Cigna Vision plans are 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 Health and Life Insurance Company and/or Cigna Dental Health, Inc. and its subsidiaries and affiliates for purposes of plan administration or for the purpose of validating and determining benefits payable. I further authorize Cigna Health and Life Insurance Company and/or Cigna Dental Health, Inc. and its subsidiaries and affiliates to release any records or information concerning me or my covered dependents to its designee, for purposes of plan administration and customer service.
- California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance coverage. Cigna Health and Life Insurance Company and/or Cigna Dental Health, Inc. and its subsidiaries and affiliates do not require such tests in any state as a condition of obtaining dental coverage.

FRAUD WARNING

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which *is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation. (In Florida, this is a felony of the third degree. In New York, the civil penalty is not to exceed five thousand dollars and the stated value of the claim for each such violation. *In Nebraska, "is" is changed to "may be").