Enrollment / Change Form

SERVING NH 25+ YEARS SCHOOLCARE HEALTH BENEFIT PLANS

cigna healthcare

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A

FOR EMPLOYER USE ONLY	Effective Date	Hire Date	Employer Name	Employer Address

☐ New Hire ☐ Open Enrollment	☐ Active ☐ Retiree ☐ COBRA	Account Number 3206140	Branch Code	Billing Group

Type of Change: See Qualifying Events on Reverse

☐ Address Change
☐ Cancel Employee*
**Must also complete COBRA Notification Request Form*
☐ Add Dependent(s): List names in Section B
☐ Cancel Dependent(s)*_____
☐ Retirement
☐ Other: _____

B

Employee Name *(last)* *(first)* *(M.I.)* | Social Security #

Cell Phone | Home Phone | E-Mail Address

Mailing Address *(Street, Apt #, or PO Box)* *(City)* *(State)* *(Zip Code)*

Last Name	**First Name**	**M.I.**	**Plan**	**Social Security #**	**Date of Birth**	**Gender**	**Relationship to Subscriber** i.e. legally married, *domestic partner, biological, step or adopted child (*not all Employers offer DP coverage)
Employee			☐ Medical ☐ Dental			☐ M ☐ F	Spouse E-mail Address
Spouse (whom you wish to cover)			☐ Medical ☐ Dental			☐ M ☐ F	☐ Legally Married ☐ Domestic Partner*
Dependent (whom you wish to cover)			☐ Medical ☐ Dental			☐ M ☐ F	☐ Biological ☐ Step ☐ Adopted
Dependent (whom you wish to cover)			☐ Medical ☐ Dental			☐ M ☐ F	☐ Biological ☐ Step ☐ Adopted
Dependent (whom you wish to cover)			☐ Medical ☐ Dental			☐ M ☐ F	☐ Biological ☐ Step ☐ Adopted

C

Traditional Plan Suite Options
☐ Green Open Access
☐ Red Open Access

Consumer Driven Plan Suite Options
☐ Yellow Open Access with Choice Fund
☐ Yellow Open Access
☐ Orange Open Access

Dental _____ (insert plan code)

If declining coverage, please initial below.
_____ **Decline Medical Coverage**
_____ **Decline Dental Coverage**

D

Other Health Care Coverage

Will you or your covered dependents have other health insurance while on SCHOOLCARE? ☐ **Yes** ☐ **No**

Name of person covered	ID Number or Medicare No.	Effective Date	Name of Carrier	Medicare Part A	Medicare Part B	Medicaid	Other Insurance Carrier
1.				☐	☐	☐	☐
2.				☐	☐	☐	☐

Signature – The information provided above is true and correct to the best of my knowledge.

E

Employee's Signature/ Date	Employer's Signature / Date

Please make a copy for both employee and employer then submit the original to SCHOOLCARE.
Please review additional information on reverse side of this form.

INSTRUCTIONS

EMPLOYER

Complete Section A - Employer and enrollment/change information
Check box(es) indicating reason(s) for submitting enrollment/change request.

Complete Section E - in the lower right hand corner of the Form
Employer must sign and date the Form after reviewing all information in order for It to be processed.

EMPLOYEE – Complete Sections B - E

Section B - Employee and Covered Dependent Information
Complete all information in order for your enrollment/change request to be processed.

- *Provide **LEGAL NAME AND MIDDLE INITIAL** for <u>all</u> enrollees.*
- *Federal regulations require **social security numbers** for <u>all</u> enrollees.*
- Provide ***valid email address(es)*** to be sure you receive information regarding wellness cash incentives.

Section C - Plan Option
Check one SCHOOLCARE medical plan option box that you are selecting as offered by your employer.

Check one SCHOOLCARE dental plan option box, if applicable, and insert plan code.

If declining coverage, initial accordingly.

Section D - Other Health Care Coverage
Only complete for covered dependents on the plan who will maintain other insurance while on SCHOOLCARE.

Section E - Employee Verification
Employee must sign and date the Form after completing and reviewing all information in order for it to be processed.

SPECIAL PROVISIONS FOR EMPLOYERS WITH SECTION 125 PLANS

By allowing an individual to enroll in the Insurance Plan other than during the open enrollment period, SCHOOLCARE, Cigna HealthCare or Cigna Health and Life Insurance Company do not waive any terms of its contracts. Further, by allowing an individual to enroll in the Insurance Plan other than during the open enrollment period, SCHOOLCARE, Cigna HealthCare or Cigna Health and Life Insurance Company do not thereby express any opinion regarding the appropriateness of the change under Section 125 of the Internal Revenue Code or the terms of the employer's Section 125 plan.

QUALIFYING EVENTS

For a qualifying event, subscribers must provide notice within **30 days** of the event. Examples include:

- Marriage
- Loss of other insurance coverage
- Adoption/ Legal Guardianship
- Birth of a child
- Death
- Divorce/ Legal Separation (Subscriber or Spouse notification within 60 days)

CIGNA HEALTHCARE PROVISIONS

Applicant Acknowledgments and Agreements

On behalf of myself and the dependents listed on the reverse side, I agree to or with the following:

1. "Cigna HealthCare" refers to various operating subsidiaries of Cigna Corporation. Products and services provided by these subsidiaries and not by Cigna Corporation. These subsidiaries include Cigna Healthcare, Cigna Health and Life Insurance Company, Cigna Home Delivery Program and its affiliates, Cigna Behavioral Health, Inc., Intracorp, and HMO or service company subsidiaries of Cigna Health Corporation and Cigna Dental Health, Inc.
2. I agree, for myself and my dependents, that, in the event any health services provided are the primary responsibility of any other party by way of other group health coverage or by the act or omission of another person to fully inform the healthplan and will execute such assignments, liens or other documents which may be necessary to enable the healthplan to recover the value of the services provided. I further agree that in the event I or any of my dependents collect benefits or damages from any other party who has primary responsibility for services provided by SCHOOLCARE, I will immediately reimburse SCHOOLCARE to the extent of services provided and to the extent permitted by state law.
3. 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 subject such person to criminal and civil penalties.
4. I authorize deductions from my earnings or the required contributions, if any, toward the cost of the coverage. This authorization applies only if employee contributions are required.