Enrollment / Change Form (Consolidated)

Employer: Complete Section A
Employee: Complete Sections B-H

Please print and thank you for providing this information

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

Cigna.

A

☑ OPEN ENROLL ☐ NEW ENROLL	☐ CHANGE ☐ REINSTATE	EFFECTIVE DATE OF ADD/CHANGE/ CANCELLATION (MM/DD/CCYY) 7/1/2017	EMPLOYER NAME Bloomfield Board of Educ	EMPLOYER ADDRESS —

CIGNA ACCOUNT NO.	DIVISION/BRANCH/LOCATION/CLASS	DATE OF HIRE (MM/DD/CCYY)	NETWORK ID	BRANCH CODE	CDH GROUP NO.	MEDICAL BEN. OPTION	DENTAL BEN. OPTION	VISION BEN. OPTION	CIGNA CHOICE FUND ANNUAL AMOUNT

TYPE OF CHANGE:

- ☐ Add Dependent(s) * Date:
- ☐ Cancel Employee Last Date of Coverage:
- ☐ Cancel Dependent(s) * Last Date of Coverage:

* List Names in Section B

- ☐ Address Change
- ☐ Transfer to COBRA
  - ☐ 18 mos. ☐ 29 mos. ☐ 36 mos.
- ☐ Family Security Benefit/Surviving Spouse
- ☐ Retirement
- ☐ Other

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

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	COVERAGE SELECTION	FULL TIME STUDENT? * Yes No	(Check one)
Employee			☐ M ☐ F	☐ Med. ☐ Vis. ☐ Dent.		☐ Add ☐ Cancel
Spouse			☐ M ☐ F	☐ Med. ☐ Vis. ☐ Dent.		☐ Add ☐ Cancel
Dependent * Relationship			☐ M ☐ F	☐ Med. ☐ Vis. ☐ Dent.	☐ ☐	☐ Add ☐ Cancel
Dependent * Relationship			☐ M ☐ F	☐ Med. ☐ Vis. ☐ Dent.	☐ ☐	☐ Add ☐ Cancel
Dependent * Relationship			☐ M ☐ F	☐ Med. ☐ Vis. ☐ Dent.	☐ ☐	☐ Add ☐ Cancel

***DEPENDENTS** - Dependents are covered under the medical plan to age 26. Proof of student status may be required for dental and/or vision coverage. If totally disabled prior to dependent eligibility end date, attach proof of disability for eligibility review.

C

MANAGED CARE MEDICAL OPTIONS: **OTHER MEDICAL OPTIONS:** **CIGNA CHOICE FUND® OPTIONS:**

CHOOSE ONE: PPO ☐ High Deductible Plan ☐

DENTAL OPTIONS:

☐ DHMO (Cigna Dental Care®)

Dental?

If you choose a Managed Care Medical Option other than Open Access Plus/IN or LocalPlus/IN, print the name of the Cigna HealthCare network. (See the cover or first page of the physician directory). Include the name of the city and state.

Cigna HealthCare of (city/state):

*If you have checked off one of the Flexible Spending Accounts in Section D, please make sure you have completed the corresponding enrollment form included in this package.

G

OTHER HEALTH CARE COVERAGE:
Do you or your dependents have other health insurance under a group plan, HMO, or Medicare? ☐ Yes ☐ No *If yes, please provide the following:*

NAME OF PERSON COVERED	SOCIAL SECURITY NO.	EFFECTIVE DATE	MEDICARE Part A	MEDICARE Part B	MEDICARE ID #	MEDICAID	OTHER INSURANCE CARRIER
			☐	☐		☐	☐
			☐	☐		☐	☐

H

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	SPOUSE'S SIGNATURE / DATE	EMPLOYER'S SIGNATURE / DATE