

Enrollment / Change Form (Consolidated)

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

Insured and/or Administered by
Cigna Health and Life Insurance Company
Cigna HealthCare of Connecticut, Inc.



Please print and thank you for providing this information

A	<input type="checkbox"/> OPEN ENROLL. <input type="checkbox"/> CHANGE <input type="checkbox"/> NEW ENROLL. <input type="checkbox"/> REINSTATE		EFFECTIVE DATE OF ADD/CHANGE/ CANCELLATION (MM/DD/CCYY)		EMPLOYER NAME Torrington Board of Education			EMPLOYER ADDRESS		
	CIGNA ACCOUNT NO. 3335863	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: <input type="checkbox"/> Add Dependent(s) * Date: _____ <input type="checkbox"/> Address Change <input type="checkbox"/> Family Security Benefit/Surviving Spouse <input type="checkbox"/> Cancel Employee Last Date of Coverage: _____ <input type="checkbox"/> Transfer to COBRA <input type="checkbox"/> Retirement <input type="checkbox"/> Cancel Dependent(s) * Last Date of Coverage: _____ <input type="checkbox"/> 18 mos. <input type="checkbox"/> 29 mos. <input type="checkbox"/> 36 mos. <input type="checkbox"/> Other _____										
* List Names in Section 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. <small>(Specify last name if different from yours)</small>		DEPENDENT SOCIAL SECURITY NO.	DATE OF BIRTH MM DD CCYY	GEN- DER	COVERAGE SELECTION	FULL TIME STUDENT? * Yes No	<small>If you choose a Managed Care Medical Option: Select your Choice of Primary Care Physician (PCP) or HealthCare Center (HCC) and enter the ID Numbers below. Note: PCP selection is optional for Open Access Plans.</small>		EXISTING PATIENT? Yes No	<small>If you choose the Cigna Dental Care Option: Enter your 1st and 2nd choice of Dental Office Number below.</small>		EXISTING PATIENT? Yes No	(check one)
Employee				<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Med. <input type="checkbox"/> Vis. <input type="checkbox"/> Dent.		PCP or HCC Choice -		<input type="checkbox"/> Yes <input type="checkbox"/> No	1st Choice - 2nd Choice -	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Add <input type="checkbox"/> Cancel	
Spouse				<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Med. <input type="checkbox"/> Vis. <input type="checkbox"/> Dent.		PCP or HCC Choice -		<input type="checkbox"/> Yes <input type="checkbox"/> No	1st Choice - 2nd Choice -	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Add <input type="checkbox"/> Cancel	
Dependent *	Relationship			<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Med. <input type="checkbox"/> Vis. <input type="checkbox"/> Dent.	<input type="checkbox"/> Yes <input type="checkbox"/> No	PCP or HCC Choice -		<input type="checkbox"/> Yes <input type="checkbox"/> No	1st Choice - 2nd Choice -	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Add <input type="checkbox"/> Cancel	
Dependent *	Relationship			<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Med. <input type="checkbox"/> Vis. <input type="checkbox"/> Dent.	<input type="checkbox"/> Yes <input type="checkbox"/> No	PCP or HCC Choice -		<input type="checkbox"/> Yes <input type="checkbox"/> No	1st Choice - 2nd Choice -	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Add <input type="checkbox"/> Cancel	
Dependent *	Relationship			<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Med. <input type="checkbox"/> Vis. <input type="checkbox"/> Dent.	<input type="checkbox"/> Yes <input type="checkbox"/> No	PCP or HCC Choice -		<input type="checkbox"/> Yes <input type="checkbox"/> No	1st Choice - 2nd Choice -	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Add <input type="checkbox"/> 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: <input type="checkbox"/> Point-of-Service (or DPP or CHA) <input type="checkbox"/> HMO <input type="checkbox"/> Point-of-Service Open Access <input type="checkbox"/> HMO Open Access <input type="checkbox"/> Open Access Plus	OTHER MEDICAL OPTIONS: <input type="checkbox"/> Preferred Provider Option (PPO) <input type="checkbox"/> Preferred Provider Access (PPA) <input type="checkbox"/> Medical Indemnity <input type="checkbox"/> OIN	CIGNA CHOICE FUND® OPTIONS: <input type="checkbox"/> HRA <input type="checkbox"/> with PPO <input type="checkbox"/> HSA <input type="checkbox"/> with Open Access Plus <input type="checkbox"/> Pharmacy HRA <input type="checkbox"/> with Indemnity <input type="checkbox"/> Dental HRA	<input type="checkbox"/> Cigna Care Network® <input type="checkbox"/> Decline Coverage OPTION # (if applicable): <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3	D FLEXIBLE SPENDING ACCOUNT OPTIONS: <input type="checkbox"/> Health Care* <input type="checkbox"/> Dependent Day Care* <input type="checkbox"/> Decline Coverage	E DENTAL OPTIONS: <input type="checkbox"/> DHMO (Cigna Dental Care®) <input type="checkbox"/> Dental PPO <input type="checkbox"/> Dental Indemnity <input type="checkbox"/> Decline Coverage	F VISION OPTIONS: <input type="checkbox"/> Cigna Vision <input type="checkbox"/> Decline Coverage
<small>If you choose a Managed Care Medical Option other than Open Access Plus, 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.</small>				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? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If yes, please provide the following:</i>						
NAME OF PERSON COVERED	SOCIAL SECURITY NO.	EFFECTIVE DATE	MEDICARE Part A	MEDICARE Part B	MEDICARE ID #	MEDICAID
			<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
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	Date	SPOUSE'S SIGNATURE / DATE	Date
EMPLOYER'S SIGNATURE / DATE			

PROVISIONS

- In Connecticut, HMO plans are offered by Cigna HealthCare of Connecticut, Inc.
- In Connecticut, the DHMO (Cigna Dental Care®) plan is underwritten or administered by Cigna HealthCare of Connecticut, Inc. The Cigna Dental PPO and Indemnity plans are underwritten or administered by Cigna Health and Life Insurance Company, with network management services provided by Cigna Dental Health, Inc.
- I agree, for myself and my covered 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, I will fully inform the health plan and will execute such assignments, liens or other documents which may be necessary to enable the health plan to recover the value of the services provided. I further agree that in the event I or any of my covered dependents collect benefits or damages from any other party who has primary responsibility for services provided by the health plan, I will immediately reimburse the health plan to the extent of services provided and to the extent permitted by state law.

FRAUD WARNING

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.

AUTHORIZATION TO DEDUCT CONTRIBUTIONS

I authorize deductions from my earnings of the required contributions, if any, toward the cost of the coverage. This authorization applies only if employee contributions are required.

SPECIAL PROVISIONS FOR EMPLOYERS WITH SECTION 125 PLANS

By allowing an individual to enroll in the health plan, other than during the open enrollment period, Cigna Health and Life Insurance Company and its affiliates do not waive any terms of its contract. Further, by allowing an individual to enroll in the health plan, other than during an open enrollment period, Cigna Health and Life Insurance Company and its affiliates 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.

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