Cigna Dental Enrollment / Change Form

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

Please print and thank you for providing this information

A

Cigna Account No.	**Effective Date of Add/Change**	Employer Name	Employer Address
3316064		City of Springfield, Massachusetts	36 Court Street, Room #18 Springfield, MA 01103

☐ Open Enrollment
☐ New Enrollment
☐ Change
☐ Reinstate

Type of Change
☐ Add Dependent(s)* ☐ Cancel Employee
☐ Cancel Dependent(s)* ☐ Address Change
☐ Transfer to COBRA
☐ 18 mos. ☐ 29 mos. ☐ 36 mos.
*List names in Section B

Branch Code
☐ ACTIVE
☐ COBRA

Dental/Vision Benefit Option
☐ **DENTAL PPO BASE**
☐ **DENTAL PPO BUY-UP**
☐ **DENTAL DHMO BUY-UP**

B

Employee Name *(last)* *(first)* *(M.I.)* | Employee ID Number

Employee Date of Birth | Home Phone | Work Phone | Home E-Mail Address

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

Last Name First Name M.I.	Dependent SSN	Date of Birth	Gender	Coverage	Dental Prov. ID **(DHMO Only)**
Employee Same As Above	Same As Above	Same As Above	☐ M ☐ F	☐ Dental ☐ Vision	
Spouse (whom you wish to cover)		| |	☐ M ☐ F	☐ Dental ☐ Vision	
Dependent (whom you wish to cover)		| |	☐ M ☐ F	☐ Dental ☐ Vision	
Dependent (whom you wish to cover)		| |	☐ M ☐ F	☐ Dental ☐ Vision	
Dependent (whom you wish to cover)		| |	☐ M ☐ F	☐ Dental ☐ Vision	

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

C

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

Cigna Provisions

- "Cigna" refers to various operating subsidiaries of Cigna Corporation. Products and services provided by these subsidiaries and not by Cigna Corporation. These subsidiaries include Connecticut General Life Insurance Company, Tel-Drug, Inc. and its affiliates, Cigna Behavioral Health, Inc., Intracorp, and HMO or service company subsidiaries of Cigna Health Corporation and Cigna Dental Health, Inc.

- 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 the healthplans I will immediately reimburse the healthplan to the extent of services provided 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 PROVISION FOR EMPLOYERS WITH SECTION 125 PLANS

By allowing an individual to enroll in the Insurance Plan other than during the open enrollment period, CIGNA HealthCare or Connecticut General Life Insurance Company does not waive any terms of its contract. Further, by allowing an individual to enroll in the Insurance Plan other than during the open enrollment period, CIGNA HealthCare or Connecticut General Life Insurance Company does 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.