Cigna Dental Enrollment Form

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

Insured and/or Administered by
Cigna Health and Life Insurance Company
900 Cottage Grove Road
Hartford, CT 06152-1038

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

Cigna Account No.	Division/Branch/Location/Class	Date of Hire (MM/DD/CCYY)	Network ID	Branch Code	CDH Group No.	Dental Benefit Option

Type of Change:

- ☐ **Add Dependent(s)*** Date: ______
- ☐ **Cancel Employee** Last Date of Coverage: ______
- ☐ **Cancel Dependent(s) *** Last Date of Coverage: ______
  - ☐ Leave employment
  - ☐ Transfer out of Cigna Dental Care area
  - ☐ Transfer to another plan

*** List Names in Section C**

- ☐ **Address Change**
- ☐ **Transfer to COBRA**
  - ☐ 18 mos. ☐ 29 mos. ☐ 36 mos.
- ☐ **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

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

What is your primary language? *(optional)*	Do you have a disability affecting your ability to communicate or read? *(optional)* ☐ Yes ☐ No	Select Plan: ☐ Cigna Dental PPO ☐ Cigna Traditional

C

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	Full-Time Student? Yes / No	Start Date of Continuous Dental Coverage *(for Cigna Dental PPO only)* *(Month, Day, Year)*	*(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.

D

SIGNATURE-The information provided above is true and correct to the best of my knowledge and belief, 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.

DISTRIBUTION: White - Cigna **Canary -** Member **Pink -** Employer

PROVISIONS

- In Maryland, the Cigna Dental PPO plan is 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) plan is 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 Dental Health, Inc. and Cigna Health and Life Insurance Company for purposes of plan administration or for the purpose of validating and determining benefits payable. I further authorize Cigna Dental Health, Inc. and Cigna Health and Life Insurance Company to release any records or information concerning me or my covered dependents to its designee, for purposes of plan administration and customer service.

FRAUD WARNING

Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

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