

CIGNA Dental Enrollment Form

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

CIGNA Dental Health, Inc.
 Insured dental plans underwritten by
 Connecticut General Life Insurance Company
 P.O. Box 22170
 Tempe, AZ 85285-2170



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		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: <table style="width:100%; border:none;"> <tr> <td style="width:15%;"><input type="checkbox"/> Add Dependent(s) *</td> <td style="width:30%;">Date: _____</td> <td style="width:15%;"><input type="checkbox"/> Address Change</td> <td colspan="5"></td> </tr> <tr> <td><input type="checkbox"/> Cancel Employee</td> <td>Last Date of Coverage: _____</td> <td><input type="checkbox"/> Transfer to COBRA</td> <td colspan="5"></td> </tr> <tr> <td><input type="checkbox"/> Cancel Dependent(s) *</td> <td>Last Date of Coverage: _____</td> <td><input type="checkbox"/> 18 mos.</td> <td><input type="checkbox"/> 29 mos.</td> <td><input type="checkbox"/> 36 mos.</td> <td colspan="3"></td> </tr> <tr> <td colspan="2">Reason for Cancellation:</td> <td colspan="2"><input type="checkbox"/> Leave employment</td> <td colspan="2"><input type="checkbox"/> Other _____</td> <td colspan="3"></td> </tr> <tr> <td colspan="2"></td> <td colspan="2"><input type="checkbox"/> Transfer out of CIGNA Dental Care area</td> <td colspan="3"></td> <td colspan="3"></td> </tr> <tr> <td colspan="2"></td> <td colspan="2"><input type="checkbox"/> Transfer to another plan</td> <td colspan="3"></td> <td colspan="3"></td> </tr> </table>													<input type="checkbox"/> Add Dependent(s) *	Date: _____	<input type="checkbox"/> Address Change						<input type="checkbox"/> Cancel Employee	Last Date of Coverage: _____	<input type="checkbox"/> Transfer to COBRA						<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.				Reason for Cancellation:		<input type="checkbox"/> Leave employment		<input type="checkbox"/> Other _____							<input type="checkbox"/> Transfer out of CIGNA Dental Care area										<input type="checkbox"/> Transfer to another plan							
<input type="checkbox"/> Add Dependent(s) *	Date: _____	<input type="checkbox"/> Address Change																																																															
<input type="checkbox"/> Cancel Employee	Last Date of Coverage: _____	<input type="checkbox"/> Transfer to COBRA																																																															
<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.																																																													
Reason for Cancellation:		<input type="checkbox"/> Leave employment		<input type="checkbox"/> Other _____																																																													
		<input type="checkbox"/> Transfer out of CIGNA Dental Care area																																																															
		<input type="checkbox"/> Transfer to another plan																																																															
* List Names in Section C																																																																	

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) <input type="checkbox"/> Yes <input type="checkbox"/> No			SELECT PLAN: <input type="checkbox"/> CIGNA Dental Care <input type="checkbox"/> CIGNA Dental EPO <input type="checkbox"/> CIGNA Dental PPO <input type="checkbox"/> CIGNA Traditional				

C	I WOULD LIKE COVERAGE FOR ME AND MY DEPENDENTS. <i>(Specify last name if different from yours)</i>			DEPENDENT SOCIAL SECURITY NO.	DATE OF BIRTH MM DD CCYY	GENDER	FULL-TIME STUDENT? Yes No	DENTAL OFFICE SELECTION <i>(for CIGNA Dental Care only)</i>	START DATE OF CONTINUOUS DENTAL COVERAGE <i>(for CIGNA Dental PPO only)</i> <small>(Month, Day, Year)</small>	<i>(check one)</i>
	Last Name	First Name	M.I.							
	Employee					<input type="checkbox"/> M <input type="checkbox"/> F		1st Choice - 2nd Choice -		<input type="checkbox"/> Add <input type="checkbox"/> Cancel
	Spouse					<input type="checkbox"/> M <input type="checkbox"/> F		1st Choice - 2nd Choice -		<input type="checkbox"/> Add <input type="checkbox"/> Cancel
	Dependent		Relationship			<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> <input type="checkbox"/>	1st Choice - 2nd Choice -		<input type="checkbox"/> Add <input type="checkbox"/> Cancel
	Dependent		Relationship			<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> <input type="checkbox"/>	1st Choice - 2nd Choice -		<input type="checkbox"/> Add <input type="checkbox"/> Cancel
	Dependent		Relationship			<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> <input type="checkbox"/>	1st Choice - 2nd Choice -		<input type="checkbox"/> Add <input type="checkbox"/> Cancel

Please submit proof of student or handicapped status for coverage dependents.
 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 I accept the provisions on the reverse side of this form which I have read and understand. EMPLOYEE'S SIGNATURE / DATE _____
----------	--

CIGNA Dental refers to the following operating subsidiaries of CIGNA Corporation: Connecticut General Life Insurance Company and CIGNA Dental Health, Inc., and its operating subsidiaries and affiliates. The CIGNA Dental Care plan is provided by CIGNA Dental Health Plan of Arizona, Inc., CIGNA Dental Health of California, Inc., CIGNA Dental Care of Colorado, Inc., CIGNA HealthCare of Connecticut, Inc., CIGNA Dental Health of Delaware, Inc., CIGNA Dental Health of Florida, Inc., a Prepaid Limited Health Services Organization licensed under Chapter 636, Florida Statutes, CIGNA Dental Health of Kansas, Inc. (Kansas and Nebraska), CIGNA Dental Health of Kentucky, Inc., CIGNA Dental Health of Illinois, Inc., CIGNA Dental Health of Maryland, Inc., CIGNA Dental Health of Missouri, Inc., CIGNA Dental Health of New Jersey, Inc., CIGNA Dental Health of North Carolina, Inc., CIGNA Dental Health of Ohio, Inc., CIGNA Dental Health of Pennsylvania, Inc., CIGNA Dental Health of Texas, Inc., and CIGNA Dental Health of Virginia, Inc. In other states, the CIGNA Dental Care plan is underwritten by Connecticut General Life Insurance Company and administered by CIGNA Dental Health, Inc. The CIGNA Dental PPO and CIGNA Dental EPO plans are underwritten or administered by Connecticut General Life Insurance Company with network management services provided by CIGNA Dental Health, Inc., and certain of its operating subsidiaries. The CIGNA Traditional plan is underwritten or administered by Connecticut General Life Insurance Company.

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.

PROVISIONS

- 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 dependents to CIGNA Dental Health and Connecticut General Life Insurance Company for purposes of plan administration or for the purpose of validating and determining benefits payable. I further authorize CIGNA Dental Health and Connecticut General Life Insurance Company to release any records or information concerning me or my dependents to its designee, for purposes of plan administration and customer service.
- California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance coverage. CIGNA Dental Health and Connecticut General Life Insurance Company do not require such tests in any state as a condition of obtaining dental coverage.

FRAUD WARNING

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 shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation. (In Florida, this is a felony of the third degree. In New York, the civil penalty is not to exceed five thousand dollars and the stated value of the claim for each such violation. *In Nebraska, "is" is changed to "may be").