Insured and/or Administered by
Cigna Health and Life Insurance Company
Cigna Dental Health of New Jersey, Inc.

Group Enrollment/Change Request

Refer to instructions before completing this form. Print clearly.

Employer Group Information - *To be completed by Employer*

EMPLOYER NAME	MEDICAL PLAN NO.	SUBGROUP	CLASS	DENTAL BEN. OPTION

(Processor: Send form to Cont. Unit: Greenwood Vig., CO - 584 if info. provided)

A. TYPE OF ACTIVITY - *To be completed by Employer*

1. Enrollment

☐ New Enrollee

Effective Date: ___/___/___

Date of Hire: ___/___/___

2. Change - *Check all that apply.*

	Date of Event	Reason
☐ Add Spouse/Civil Union Partner	___/___/___	
☐ Add Domestic Partner	___/___/___	
☐ Add Dependent Child	___/___/___	
☐ Add Over-Age Child as Dependent Under 31 (complete section A4)	___/___/___	
☐ Name Change	___/___/___	
☐ Change Plan	___/___/___	
☐ Add/Change Office ID Numbers (Primary, OB/Gyn, Dentist)	___/___/___	
☐ Other	___/___/___	

3. Remove or Terminate - *Check all that apply.*

	Effective Date	Reason
☐ Remove Spouse/Civil Union Partner*	___/___/___	
☐ Remove Domestic Partner*	___/___/___	
☐ Remove Dependent Child*	___/___/___	
☐ Remove Over-Age Child as Dependent Under 31*	___/___/___	
☐ Employee Withdrawal/Termination	___/___/___	

NOTE: Employee must be enrolled for spouse/domestic partner/dependent(s) to have coverage.

*Please complete *Add/Change/Remove* and *Name* columns in Section D.

4. Continuation of Coverage, i.e., COBRA, State, Total Disability
Not all options are available. Contact Employer for available options.

Coverage For: ☐ Employee ☐ Spouse/Civil Union Partner ☐ Dependent

Length of Continuation: ☐ 12 mos. ☐ 18 mos. ☐ 29 mos. ☐ 36 mos. ☐ Total Disability* ☐ To Age 31

Date of Loss of Coverage: ___/___/___ Billing: ☐ Group

Date of Qualifying Event: ___/___/___ ☐ Home (Section B)

Qualifying Event Type**: _____

Attach proof of total disability** ****See list in Instructions

Additional Information for Dependent Under 31 Continuation Elections - Provide information about children listed in Section D for whom a Dependent Under 31 continuation election is being made.

☐ During an Open Enrollment period:
☐ for the group ☐ for the Over-Age Child based on his/her age-out anniversary

☐ Prior to the attainment of the limiting age (when Dependent will become an Over-Age Child)

☐ After the Over-Age Child has established eligibility for a Chapter 375 Continuation Election

B. EMPLOYEE INFORMATION - Complete Sections B-G

SOCIAL SECURITY NUMBER/EMPLOYEE IDENTIFICATION NUMBER	LAST NAME, FIRST NAME, M.I.		EMPLOYEE DATE OF BIRTH (MM/DD/YYYY)	
HOME TELEPHONE ( )	HOME ADDRESS	APT. NO.	CITY, STATE	ZIP CODE
EMPLOYER NAME			WORK TELEPHONE ( )	
WORK ADDRESS		CITY, STATE		ZIP CODE
DATE OF EMPLOYMENT		HOURS WORKED PER WEEK		

C. PLAN OPTION - Your selection must be offered by your employer. *Check One.*

MEDICAL CARE PLANS:

PPO Medical Care Plans:
- ☐ PPO
- ☐ H.S.A. PPO
- ☐ HRA PPO
- ☐ Cigna Consumer Advantage® PPO
- ☐ Decline Coverage

Cigna Open Access Plans - Medical:
- ☐ Open Access Plus
- ☐ Open Access Plus In-Network
- ☐ H.S.A. Open Access Plus
- ☐ HRA Open Access Plus
- ☐ Cigna Consumer Advantage® Open Access Plus

- ☐ Indemnity
- ☐ Cigna Care Network
- ☐ Decline Coverage

FLEXIBLE SPENDING ACCOUNT OPTIONS:
- ☐ Health Care
- ☐ Dependent Care
- ☐ Decline Coverage

DENTAL OPTIONS:
- ☐ DHMO (Cigna Dental Care)
- ☐ Cigna Dental PPO
- ☐ Cigna Traditional
- ☐ Decline Coverage

VISION OPTIONS:
- ☐ Cigna Vision
- ☐ Decline Coverage

D. INDIVIDUALS COVERED - List individuals for whom you are adding/changing/removing coverage. Attach sheet to list additional children. 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.

	(A)dd (C)hange (R)emove	LAST NAME, FIRST NAME, M.I.	SEX M	SEX F	BIRTHDATE MM DD YYYY	SOCIAL SECURITY NUMBER	OTHER HEALTH COVERAGE? (if yes, attach details) Yes	PRIMARY/DENTAL OFFICE ID NUMBER	CURRENT PATIENT? Yes	PROVIDER NPI NUMBER	PREVIOUS COVERAGE? Yes
Employee			☐	☐	/ /		☐		☐		☐
Spouse/Civil Union Partner			☐	☐	/ /		☐		☐		☐
Domestic Partner			☐	☐	/ /		☐		☐		☐
Child			☐	☐	/ /		☐		☐		☐
Child			☐	☐	/ /		☐		☐		☐
Child			☐	☐	/ /		☐		☐		☐

E. OTHER/PREVIOUS INSURANCE

IS YOUR SPOUSE EMPLOYED? ☐ Yes ☐ No IF "YES", GIVE NAME & ADDRESS OF SPOUSE'S EMPLOYER

IF "YES" TO OTHER HEALTH COVERAGE (SECTION D), GIVE NAME & POLICY NUMBER OF INSURANCE CARRIER, HMO, OR OTHER SOURCE.
IF ENROLLED IN MEDICARE PARTS A AND/OR B, IDENTIFY THE COVERAGE AND PROVIDE THE MEDICARE ID #.

IF "YES" TO PREVIOUS COVERAGE (SECTION D), IDENTIFY NAME(S) OF PERSONS, GIVE EFFECTIVE DATE AND DATE COVERAGE TERMINATED, NAME OF PREVIOUS CARRIER AND PLAN NUMBER.

F. DEPENDENT/SPOUSE/CIVIL UNION PARTNER INFORMATION

DOES ANY DEPENDENT LISTED IN SECTION D LIVE AT A DIFFERENT ADDRESS THAN THE EMPLOYEE? ☐ Yes ☐ No IF "YES", WHO AND WHAT ADDRESS?

EXPLAIN THE CIRCUMSTANCES

IF ANY DEPENDENT'S LAST NAME DIFFERS FROM YOURS, EXPLAIN THE CIRCUMSTANCES. USE ADDITIONAL PAPER AND ATTACH.

G. EMPLOYEE/OVER-AGE CHILD SIGNATURE

I represent that all the information supplied in this application is true and complete. I hereby agree to the conditions of enrollment on the reverse side of the employee/over-age child copy of this enrollment/change request. I authorize deductions from my earnings for any required contributions.

EMPLOYEE SIGNATURE - ***Required*** X _____ DATE ___/___/___

OVER-AGE CHILD SIGNATURE X _____ DATE ___/___/___

*H. RACE/ETHNICITY *(Optional)*

***Responding to this question is optional and not required.**

Choose a category that most closely describes you:

- ☐ a. American Indian or Alaskan Native
- ☐ b. Asian or Pacific Islander
- ☐ c. Black, not of Hispanic origin
- ☐ d. Hispanic
- ☐ e. White, not of Hispanic origin

I. EMPLOYER VERIFICATION - *To be completed by Employer*

EMPLOYER SIGNATURE - ***Required*** X _____

TITLE _____ DATE ___/___/___

NJ-HINT-Group

Coverage must be verified with Cigna prior to visiting a specialist or admission to a hospital.

INSTRUCTIONS

EMPLOYER

- Complete the **Employer Group Information** in the upper right corner of the form.
- **Section A - Type of Activity:** Check box(es) indicating reason(s) for submitting enrollment/change request.
- Complete **Section I - Employer Verification** in the lower right corner of the form.
  - Employer must complete this section for all new enrollments, coverage changes and terminations.
  - Employer must sign and date the application in order for it to be processed.

EMPLOYEE - Complete Sections B-H

Section B - Employee Information:

Complete **all** information in order for your enrollment/change request to be processed. Please PRINT except when a signature is requested.

Section C - Plan Option:

- Check one Plan Option box, indicate Plan Option Name (where applicable) and check *one* Primary Copay and/or Individual Deductible Amount (if applicable).
- Select only an option offered by your employer.

Section D - Individuals Covered:

- Add/Change/Remove - Use "A", "C", or "R" to indicate whether you are adding, changing or removing coverage for an individual.
- Print your full name along with the name(s) of your dependent(s), if applicable. Indicate Sex, Birthdate, and Social Security Number for each individual listed.
- If a dependent is disabled, and you want to continue his or her coverage beyond age 26, you do not have to make a "Continuation of Coverage" election. Instead, select "Add Over-Age Child ..." in Section A.2., and attach proof of disability.
- If you or your dependent(s) have other Health coverage, check off the "Yes" box(es) and complete Section E - Previous Insurance.
- From the appropriate provider directory, locate the **10-digit** office ID number for the primary care physician, ob/gyn (if applicable) and/or dentist (if applicable). Indicate office ID number selection(s) on the form.
- If you are a current patient, please check the "Current Patient" box.
- You can obtain the providers' correct ID numbers from the appropriate provider directory. You may also obtain each provider's NPI number at www.cigna.com or by contacting the provider directly. Providers with multiple office locations and individual providers who belong to more than one practice or provider entity may have more than one NPI number. You should confirm the correct NPI number for the specific provider and office location where you will be seen by contacting that office directly.

Section E - Previous Insurance:

Complete this section for all new enrollments or coverage changes. Coverage includes group coverage, governmental coverage, a church plan or Medicare.

Section F - Dependent Information:

Complete this section for all new enrollments or coverage changes.

Section G - Employee/Over-Age Child Signature:

- Complete this section for all new enrollments, coverage changes and terminations.
- Employee/Over-Age Child must sign and date the enrollment/change request in order for it to be processed.

Section I - Employer Verification:

- Employer must complete this section for all new enrollments, coverage changes and terminations.
- Employer must sign and date the enrollment/change request in order for it to be processed.

CONDITIONS OF ENROLLMENT

Acknowledgments and Agreements

On behalf of myself and the dependents listed on this Group Enrollment/Change Request Form, I acknowledge that:

1. I authorize any physician or medical professional, hospital, clinic or other medical care institution, carrier, consumer reporting agency, and any employer to give Cigna Health and Life Insurance Company and Cigna Dental Health of New Jersey, Inc., or any consumer reporting agency acting on behalf of Cigna Health and Life Insurance Company and Cigna Dental Health of New Jersey, Inc., information pertaining to employment, other health coverage, and medical advice, treatment or supplies for any physical or mental condition relevant to me or a minor dependent applying for coverage. I agree that this authorization shall be valid for 30 months from the date I sign this Enrollment/Change Request form, unless revoked at an earlier date.
2. I agree that, if I revoke this authorization before it expires, such revocation shall not affect any action that Cigna Health and Life Insurance Company and Cigna Dental Health of New Jersey, Inc. have taken in reliance on the authorization.
3. I understand I may receive a copy of this authorization if I request one. I agree that a photocopy of this authorization is as valid as the original.
4. I agree Cigna Health and Life Insurance Company and Cigna Dental Health of New Jersey, Inc. will provide coverage in accordance with the terms of the contract for the group policy.
5. I agree that the provision of coverage and benefits is contingent upon payment of premiums and may be terminated in accordance with the terms of the group policy if premiums are not paid timely. I authorize my Employer to withhold payments from my wages as contribution to the premium, as appropriate. I understand that any person who includes any false or misleading information on an application or enrollment form for a health benefits plan is subject to criminal and civil penalties.

Qualifying Events

For COBRA, State Continuation, Total Disability:

C1. Termination of job or reduction in hours
C2. Employee enrollment in Medicare (COBRA only)
C3. Divorce (COBRA/NJSGC); civil union dissolution (NJSGC)
C4. Death of employee
C5. Loss of dependent child status under the plan
C6. Disability (occurring subsequent to another qualifying event)

For Dependents Under 31:

D1. Loss of dependent status and otherwise eligible
D2. Reestablish eligibility: residency
D3. Reestablish eligibility: nonresident full-time student
D4. Reestablish eligibility: change in marital status
D5. Reestablish eligibility: change in parental status
D6. Reestablish eligibility: termination of other coverage