# *Enrollment/Change Form*

**Employee: Complete Sections A and B.**
**Then Sign and Date Section C.**

**CIGNA HealthCare of New York, Inc.**
P.O. Box 2010
Concord, NH 03302
Fax #: 603-229-2980

CIGNA

## SECTION A: EMPLOYEE AND DEPENDENT INFORMATION *(Do Not Write in Shaded Boxes)*

| 1. Subscriber Name *(Last, First, M.I.)* | 2. Social Security No. | 3. Home Phone | 4. Business Phone |
|---|---|---|---|
| | | | |

| 5. Address *(No.)* *(Street)* *(City)* *(State)* *(Zip)* | 6. County | CN |
|---|---|---|
| | | |

**List All Persons To Be Enrolled Or Affected By A Change**

| | 7. Last Name First Middle Initial | 8. Birthdate Mo. Day Yr. | 9. Sex | 10. You must select a Primary Care Physician. Please enter your preferred selection and an alternate in the event your first is not available. | 11. Physician ID No. | 12. New Patient Yes No |
|---|---|---|---|---|---|---|
| 01 | Subscriber | | ☐ M ☐ F | First Choice | | ☐ ☐ |
| | | | | Alternate Choice | | ☐ ☐ |
| 02 | Spouse Relationship | | ☐ M ☐ F | First Choice | | ☐ ☐ |
| | | | | Alternate Choice | | ☐ ☐ |
| 03 | First Dependent Relationship | | ☐ M ☐ F | First Choice | | ☐ ☐ |
| | | | | Alternate Choice | | ☐ ☐ |
| 04 | Second Dependent Relationship | | ☐ M ☐ F | First Choice | | ☐ ☐ |
| | | | | Alternate Choice | | ☐ ☐ |
| 05 | Third Dependent Relationship | | ☐ M ☐ F | First Choice | | ☐ ☐ |
| | | | | Alternate Choice | | ☐ ☐ |

| 13. Complete If Enrolling Dependent(s) Age 19 Or Over | Dependent's Name — Full-Time Student ☐ Yes ☐ No | Dependent's Name — Full-Time Student ☐ Yes ☐ No |
|---|---|---|
| 14. Complete If Enrolling A Handicapped Dependent Age 19 Or Over In Addition To Above | Handicapped Dependent's First Name *(Attach Doctor's Statement)* | 15. Complete If Enrolling An Adopted Child Or Stepchild — Enter Child's Complete Name And Date Adopted/Marriage Date |

## SECTION B: OTHER COVERAGE (COB) INFORMATION

| 16. Spouse's Social Security No. | 17. Is Spouse Employed? ☐ Yes ☐ No | 18. If "Yes", Spouse's Employer Name And Address |
|---|---|---|
| | | |

| 19A. Does your spouse have other Insurance? ☐ Yes ☐ No | 19B. If yes, Name, Address And Policy No. Of Insurance Company / HMO Providing Medical Benefits At Spouse's Employer | 20. Are You Or Any Of Your Dependents Covered Under Your Spouse's Benefit Plan Or HMO? You ☐ Yes ☐ No Dependent(s) ☐ Yes ☐ No |
|---|---|---|
| | | |

*Complete the following if you or any dependent is covered by any Insurance, HMO, Medicaid or Medicare, other than the plan identified in Box 19B.*

| 21. Name Of Person | 22. Type Of Coverage & Policy No. | 23. Insurance Company/HMO Name And Address | 24. Effective Date | 25. Medicare Part A | Part B | Part A & B |
|---|---|---|---|---|---|---|
| | | | | ☐ | ☐ | ☐ |
| | | | | ☐ | ☐ | ☐ |

| 26. Have You Or Your Dependents Ever Been A CIGNA HealthCare Member? ☐ Yes ☐ No as: ☐ Enrollee ☐ Dependent | If Yes, Under What Name and Social Security No.? | At CIGNA HealthCare Of: |
|---|---|---|
| | | |

## SECTION C: EMPLOYEE SIGN AND DATE THE FORM

"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 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."

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. (The subscriber is responsible for the total cost of care received or for drugs purchased which are not authorized by the plan.)

| 27. Subscriber's Signature | 28. Date | 29. Si prefiere recibir el material de post-inscripción en Español, por favor marque aquí ☐ |
|---|---|---|
| | | |

## SECTION D: EMPLOYER - COMPLETE THE FOLLOWING *(Do Not Write in Shaded Boxes)*

| 30. **Check One:** ☐ **Open enrollment** ☐ **New Employee** ☐ **Change** ☐ **Cancellation** | 31. Effective Date Or Cancellation Date |
|---|---|
| | |

| 32. Employer Name | 33. Date Of Hire | 34. Group No. | 35. Division No. | Contract Type |
|---|---|---|---|---|
| | | | | |

36. Changes *(Check Appropriate Boxes)*

- ☐ Add Dependent
- ☐ Address Change
- ☐ Convert To COBRA
  - ☐ 18 Mos. ☐ 29 Mos. ☐ 36 Mos.
- ☐ Convert To Non-Group CIGNA HealthCare
- ☐ Physician Change
- ☐ ID Card Request *(List Names In Box 7)*
- ☐ Name Change
- ☐ Reinstatement of Coverage
- ☐ Cancel All Coverage
- ☐ Cancel All Dependents
- ☐ Cancel Named Dependent(s) Only *(List Names In Box 7)*
  - ☐ Marriage ☐ Divorce
  - ☐ Age Limit
  - ☐ Change In Student Status
  - ☐ Other _____

## PROVISIONS

I authorize deductions from my earnings of the required contributions, if any, toward the cost of the coverage.

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I understand that the Participating Providers, if any, do not necessarily include all types of doctors or providers.

I authorize payment of benefits to the Participating Provider of the benefits.

I authorize any Provider, Insurance Company, Employer or Organization to release any information, on me or my dependents, regarding the medical, dental, mental, alcohol or drug abuse history, treatment or benefits payable, including disability or employment related information, to the Plan Administrator or its authorized agent for the purpose of validating and determining benefits payable in connection with this Plan.

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I authorize that payment be made under Part B of Medicare to CIGNA HealthCare for medical and other services furnished me for which it pays or has paid, if applicable.

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 CIGNA HealthCare 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 understand and agree that, in the event I or any of my dependents collect compensation from any other party for settlement or judgement, CIGNA HealthCare reserves the right to recover any funds previously paid by CIGNA HealthCare for medical services and benefits when the amounts received by myself or my dependents are specifically identified as reimbursements for those services.