



**CIGNA HealthCare**  
**SECTION A – FOR EMPLOYEE TO COMPLETE – Please Complete in Ink**

- PPN/PPO
- PHCS Network
- Other (specify) \_\_\_\_\_

**New Enrollment (Complete Sections A, C, D and E)**     **Enrollment Change (Complete All Sections)**     **Coverage Waived (Complete Section A & E)**

Social Security Number (Required Information)    Last Name    First    Initial    Marital Status

\_\_\_\_\_    \_\_\_\_\_    \_\_\_\_\_    \_\_\_\_\_     S     M     D     W

Date of Hire    Address    Apt. #    City    State    Zip Code

Name of Employer    Your Job Title    Date of Full-Time Employment    Hours worked per week

Coverage Desired:     Employee Only     Employee & Spouse     Employee & Deps.     Employee Spouse & Deps.

**SECTION B – FOR ENROLLMENT CHANGES**

Reason for Change (Check all applicable boxes)    Change Effective Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Add Spouse – Date of Marriage \_\_\_\_/\_\_\_\_/\_\_\_\_ (Complete Section C, D and E)

Add Dependent Child – Date of Birth/Adoption \_\_\_\_/\_\_\_\_/\_\_\_\_ (Complete Section C, D and E)

Delete Dependent(s) – (Complete Section C and E)

Name Change – List Former Name Here \_\_\_\_\_

Address or Phone # Change (Show New Address or Phone # in Section A)

Change in Plant/Division

Other, (please explain) \_\_\_\_\_

**Terminate Enrollment of Employee and All Family Dependents – Reason for Termination:**

Left Employment     Layoff/LOA

Death     Ineligible

Dissatisfied with Physician     Transferred

Cost

Other, (Please explain) \_\_\_\_\_

Termination Effective Date: \_\_\_\_\_

**SECTION C – ADDITIONAL INFORMATION (COMPLETE WITH NEW ENROLLMENT OR CHANGED INFORMATION)**

Check One		Last Name, First Name, M.I.	Sex	Date of Birth (Month Day Year)	Social Security Number	Pre-existing end-date*	Full-Time Student?
Add	Delete						
<input type="checkbox"/>	<input type="checkbox"/>	Employee		/ /			
<input type="checkbox"/>	<input type="checkbox"/>	Spouse		/ /			
<input type="checkbox"/>	<input type="checkbox"/>	Dependent		/ /			Yes <input type="checkbox"/> No <input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Dependent		/ /			Yes <input type="checkbox"/> No <input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Dependent		/ /			

Identify Handicapped Dependent(s)    Name \_\_\_\_\_    Name \_\_\_\_\_    \* To be completed by employer.

**SECTION D – OTHER INSURANCE**

Are you, your spouse or dependent(s) covered by Medicare or any other Health Insurance?     Yes     No    **If yes, please complete the following:**

Spouse's or Dependent's Employer: \_\_\_\_\_    Employee's Phone No.: \_\_\_\_\_    Effective Date: \_\_\_\_\_

Name of Health Insurance Company: \_\_\_\_\_    Policy #: \_\_\_\_\_

Names of individual covered by other insurance: \_\_\_\_\_

**SECTION E – APPLICATION AUTHORIZATION**

**Check One:**

I hereby request enrollment of myself and eligible family dependents listed above and authorize my employer to deduct from my wages or salary the amount of contributions, if any, for the coverage requested. I understand that the coverage provided will be subject to the terms and conditions of the group insurance policy. I authorize any licensed physician, hospital, clinic, pharmacist, employer, and all other agencies or organizations to permit CIGNA HealthCare to see, or to get a copy of, all medical records, prescribed drug, employment and insurance coverage records which pertain to me or my enrolled dependents. The information above is true and correct to the best of my knowledge and I understand that my benefits may be affected by failure to provide complete, accurate and timely information. A copy of this authorization may be as valid as the original.

OR – I hereby waive all coverages offered to me.

Signature \_\_\_\_\_    Date \_\_\_\_\_    Policyholder Representative Signature \_\_\_\_\_    Date \_\_\_\_\_

**FOR CARRIER USE ONLY**

Group # \_\_\_\_\_    Acct # \_\_\_\_\_    Bpkg. \_\_\_\_\_    Tier \_\_\_\_\_    Coverage Eff. Date \_\_\_\_\_

*White & Yellow Copies – CIGNA HealthCare      Pink – Employer      Goldenrod – Employee (use as a temporary ID card)*