

# 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



Please print and thank you for providing this information

<b>A</b>	<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	
	<b>TYPE OF CHANGE:</b> <div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> <input type="checkbox"/> <b>Add Dependent(s) *</b>    Date: _____  <input type="checkbox"/> <b>Cancel Employee</b>            Last Date of Coverage: _____  <input type="checkbox"/> <b>Cancel Dependent(s) *</b>    Last Date of Coverage: _____            Reason for Cancellation:  <input type="checkbox"/> Leave employment  <input type="checkbox"/> Transfer out of CIGNA Dental Care area  <input type="checkbox"/> Transfer to another plan         </div> <div style="width: 45%;"> <input type="checkbox"/> <b>Address Change</b>  <input type="checkbox"/> <b>Transfer to COBRA</b>  <input type="checkbox"/> 18 mos.    <input type="checkbox"/> 29 mos.    <input type="checkbox"/> 36 mos.  <input type="checkbox"/> <b>Other</b> _____         </div> </div> <p style="text-align: center;">* List Names in Section C</p>								

<b>B</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) <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		

<b>C</b>	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> (Month, Day, Year)	<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

*Proof of student or handicapped status for coverage 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.*

<b>D</b>	<b>SIGNATURE</b> - 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 _____									

**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

- The CIGNA Dental Care (DHMO) plan is underwritten or administered by CIGNA Dental Health Plan of Arizona, Inc., CIGNA Dental Health of California, Inc., CIGNA Dental Health of Colorado, 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 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 CIGNA Health and Life Insurance Company or CIGNA HealthCare of Connecticut, Inc. and administered by CIGNA Dental Health, Inc.
- The term "DHMO" is used to refer to product designs that may differ by state of residence of enrollee, including but not limited to, prepaid plans, managed care plans, and plans with open access features.
- The CIGNA Dental PPO and EPO plans are 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 (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 Health and Life Insurance Company and/or CIGNA Dental Health, Inc. and its subsidiaries and affiliates for purposes of plan administration or for the purpose of validating and determining benefits payable. I further authorize CIGNA Health and Life Insurance Company and/or CIGNA Dental Health, Inc. and its subsidiaries and affiliates to release any records or information concerning me or my covered 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 Health and Life Insurance Company and/or CIGNA Dental Health, Inc. and its subsidiaries and affiliates 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").

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