Enrollment / Change Form (Consolidated)

A

☐ Open Enroll. ☐ Change
☐ New Enroll. ☐ Reinstate

Effective Date	Employer Name	Employer Address
	Regional School District #17	

Account Number	Date of Hire	Branch Code	Medical Option	Dental Option
3337932				

Type of Change
☐ Add Dependent(s)* Date:____________ ☐ Address Change
☐ Cancel Employee
☐ Cancel Dependent(s)*
*List Name in Section B

B

Employee Name *(last)* *(first)* *(M.I.)* | Date of Birth | Social Security No.

Home Phone | Work Phone | Home E-Mail Address (optional)

Address*(Street)* *(City)* *(State)* *(Zip Code)*

Last Name	First Name	M.I.	Relationship	Dependent SSN	Date of Birth	Gender	Coverage Selection
Employee				| |	| |	☐ M ☐ F	☐ Medical ☐ Dental
Spouse				| |	| |	☐ M ☐ F	☐ Medical ☐ Dental
Dependent				| |	| |	☐ M ☐ F	☐ Medical ☐ Dental
Dependent				| |	| |	☐ M ☐ F	☐ Medical ☐ Dental
Dependent				| |	| |	☐ M ☐ F	☐ Medical ☐ Dental

*DEPENDENTS – Dependents are covered under the medical plan to age 26. If totally disabled prior to dependent eligibility end date, attach proof of disability for eligibility review.

C

Options:
☐ OAP In-Network (HMO) ☐ Dental Only
☐ Open Access Plus (OAP) ☐ Decline Coverage

D

Other Health Care Coverage
Do you or any of your dependents have other health insurance under a group plan? ☐ Yes ☐ No If yes, please provide the following:
Other Insurance Company:

Name of person covered	Social Security No.	Effective Date	Medicare Part A	Medicare Part B	Medicaid	Carrier
1.			☐	☐	☐	☐
2.			☐	☐	☐	☐

E

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 understood.

Employee's Signature/ Date	Employer's Signature / Date

PROVISIONS

- "CIGNA HealthCare" refers to various operating subsidiaries of CIGNA Corporation. Products and services are provided by these subsidiaries and not by CIGNA Corporation. These subsidiaries include Connecticut General Life Insurance Company, Tel-Drug, Inc. and its affiliates, CIGNA Behavioral Health, Inc., Intracorp, and HMO or service company subsidiaries of CIGNA Health Corporation and CIGNA Dental Health, Inc.

- 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 the healthplan 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 agree that in the event I or any of my dependents collect benefits or damages from any other party who has primary responsibility for services provided by the healthplan, I will immediately reimburse the healthplan to the extent of services provided, to the extent permitted by state law.

FRAUD WARNING

Any person who, knowingly and with intent to defraud any insurance company or other person: (1) files an application for insurance or statement of claim containing any materially false information; or (2) conceals for the purpose of misleading, information concerning any material fact thereto, commits a fraudulent insurance act.

AUTHORIZATION TO DEDUCT CONTRIBUTIONS

I authorize deductions from my earnings of the required contributions, if any, toward the cost of the coverage. This authorization applies only if employee contributions are required.

SPECIAL PROVISION FOR EMPLOYERS WITH SECTION 125 PLANS

By allowing an individual to enroll in the Insurance Plan other than during the open enrollment period, CIGNA HealthCare or Connecticut General Life Insurance Company does not waive any terms of its contract. Further, by allowing an individual to enroll in the Insurance Plan other than during an open enrollment period, CIGNA HealthCare or Connecticut General Life Insurance Company does not thereby express any opinion regarding the appropriateness of the change under Section 125 of the Internal Revenue Code or the terms of the employer's Section 125 Plan.