Employer: Complete Section A **Employee:** Complete Section B-H

Enrollment/Change Form - DENTAL ONLY

Insured and/or Administered by Cigna Health and Life Insurance Company, or its affiliates

Select one

A

☐ OPEN ENROLL ☐ CHANGE ☐ NEW ENROLL ☐ REINSTATE	EFFECTIVE DATE OF CHANGE ADD/CHANGE/CANCELLATION (MM/DD/CCYY) ____/____/____	EMPLOYER NAME TOWN OF MILFORD	DATE OF HIRE (MM/DD/CCYY) ____/____/____	PLAN NUMBER 3346757	SUBGROUP 1023	CLASS 0

B

☐ SINGLE ☐ MARRIED ____/____/____
☐ SEPARATED ☐ DIVORCED ☐ WIDOWED

TYPE OF CHANGE ☐ Add Dependent(s) * ☐ Demographics ☐ PCP Change ☐ Retirement
* List Name(s) in Section C ☐ COBRA Continuation Qualifying Event Date:__/__/__ ☐ Other____________

C

EMPLOYEE NAME *(Last)*	*(First)*	SOCIAL SECURITY NUMBER - -
EMPLOYEE DATE OF BIRTH (MM/DD/CCYY) ______/______/______	HOME PHONE (________)	EMAIL ADDRESS

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

☐ YES, I WOULD LIKE COVERAGE FOR MYSELF AND MY DEPENDENTS. (Specify last name if different from yours) Last Name First Name	DEPENDENT SOCIAL SECURITY NUMBER	DATE OF BIRTH (MM/DD/CCYY)	GEN-DER	COVERAGE SELECTION	Full-Time Student? Yes No	Please list PCP below (optional)	Dental Late Entrant? Yes No	If you choose the Cigna Dental Care Option: Enter your 1st and 2nd choice of Dental Office Number below.	Existing Patient? Yes No	Check One
Employee	- -	/ /	☐M ☐F	☐Medical ☐Dental ☐Vision	☐ ☐		☐ ☐	1st Choice - 2nd Choice -	☐ ☐	☐Add ☐Cancel
Dependent* Relationship	- -	/ /	☐M ☐F	☐Medical ☐Dental ☐Vision	☐ ☐		☐ ☐	1st Choice - 2nd Choice -	☐ ☐	☐Add ☐Cancel
Dependent* Relationship	- -	/ /	☐M ☐F	☐Medical ☐Dental ☐Vision	☐ ☐		☐ ☐	1st Choice - 2nd Choice -	☐ ☐	☐Add ☐Cancel
Dependent* Relationship	- -	/ /	☐M ☐F	☐Medical ☐Dental ☐Vision	☐ ☐		☐ ☐	1st Choice - 2nd Choice -	☐ ☐	☐Add ☐Cancel
Dependent* Relationship	- -	/ /	☐M ☐F	☐Medical ☐Dental ☐Vision	☐ ☐		☐ ☐	1st Choice - 2nd Choice -	☐ ☐	☐Add ☐Cancel

ADDITIONAL INFORMATION - * DEPENDENTS – If totally disabled prior to age 26, attach proof of disability for eligibility review. Dependents are covered under the medical plan to age 26. Proof of student status may be required for dental and/or vision coverage.

D MEDICAL OPTIONS:

- ☐ Tiered Benefits®
- ☐ PPO
- ☐ HRA
- ☐ HSA (with Banking)
- ☐ HSA (without Banking)
- ☐ Open Access Plus
- ☐ Open Access Plus In-Network
- ☐ Indemnity
- ☐ LocalPlus®
- ☐ LocalPlus® IN
- ☐ Decline Coverage

E DENTAL OPTIONS:

- ☐ Cigna Traditional ________________
- ☐ Cigna Dental PPO ____High____Low
- ☐ Cigna Dental Care® DHMO ________________
- ☐ Cigna Dental EPO ________________
- ☐ Decline Coverage

VISION OPTIONS:

- ☐ Cigna Vision
- ☐ Decline Coverage

F FLEXIBLE SPENDING ACCOUNT OPTIONS:

- ☐ Healthcare **
- ☐ Dependent Care **
- ☐ Decline Coverage

** If you have elected one of the Flexible Spending Accounts in this section, please complete the corresponding enrollment form included in this package.

G OTHER HEALTHCARE COVERAGE: Do you or your dependents have other health insurance under a group plan, HMO, or Medicare? ☐ Yes ☐ No If yes, please provide the following:

NAME OF PERSON COVERED	SOCIAL SECURITY NUMBER	EFFECTIVE DATE	MEDICARE Part A	MEDICARE Part B	MEDICAID	OTHER INSURANCE CARRIER
	- -	____/____/____	☐	☐	☐	
	- -	____/____/____	☐	☐	☐	

H 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. **By my signature below, I acknowledge that I have read and understand the disclosure in this Enrollment/Change Form. I authorize the required payroll deduction for contributory benefits. I also represent that all information shown on this Enrollment/Change Form is correct. I understand that I will not be individually denied coverage or be individually charged different rates as a result of my answers. However, if I knowingly provide false information on this questionnaire, I understand and agree that it may affect the payment of claims or result in termination of my/or my dependent(s) coverage.**

EMPLOYEE SIGNATURE / DATE

PROVISIONS

- Cigna Medical, Dental Traditional, Dental EPO and Vision plans are underwritten or administered by Cigna Health and Life Insurance Company (CHLIC).
- Cigna Dental PPO 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 subsidiaries.
- Cigna Dental Care (DHMO) plans are underwritten or administered by the following operating subsidiaries of Cigna Dental Health, Inc.: Cigna Dental Health of Delaware, Inc. and Cigna Dental Health of Kansas, Inc. (Kansas and Nebraska). In other states, Cigna Dental Care plans are underwritten or administered by CHLIC or Cigna HealthCare of Connecticut, Inc., and administered by Cigna Dental Health, Inc.
- I agree, for myself and my covered 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, I will fully inform the health plan and will execute such assignments, liens or other documents which may be necessary to enable the health plan to recover the value of the services provided. I further agree that in the event I or any of my covered dependents collect benefits or damages from any other party who has primary responsibility for services provided by the health plan, I will immediately reimburse the health plan 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 PROVISIONS FOR EMPLOYERS WITH SECTION 125 PLANS

By allowing an individual to enroll in the health plan, other than during the open enrollment period, Cigna Health and Life Insurance Company and its affiliates do not waive any terms of its contract. Further, by allowing an individual to enroll in the health plan, other than during an open enrollment period, Cigna Health and Life Insurance Company and its affiliates do 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.