CIGNA Dental and Vision Enrollment Form

Please Print

EFFECTIVE DATE: *(Month, Day, Year)*

CIGNA Dental Health, Inc.
P.O. Box 189060
300 NW 82nd Avenue
Plantation, FL 33318-9060

Insured dental and vision plans are underwritten by
[Connecticut General Life Insurance Company
900 Cottage Grove Road
Hartford, CT 06152]

CIGNA Dental

PLEASE MARK APPROPRIATE BOX: ☐ New enrollment ☐ Reinstate ☐ Change ☐ Cancellation - Reason for Cancellation: ☐ Leave employment ☐ Transfer out of CIGNA Dental Care area ☐ Transfer to another plan

Any person who knowingly and with intent to injure, defraud, or deceive any insurer, files a statement of claim or an application containing any false, incomplete, or misleading information is* guilty of insurance fraud and subject to civil and criminal penalties. (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").

NOTE: PLEASE COMPLETE ALL INFORMATION

NAME *(Last, First, Middle Initial)*	SOCIAL SECURITY NUMBER	DATE OF BIRTH

ADDRESS *Apt. #* *City* *State* *Zip Code*

TELEPHONE	E-MAIL ADDRESS	WHAT IS YOUR PRIMARY LANGUAGE? *(optional)*
Home: ( ) Work: ( )		

EMPLOYER	DATE EMPLOYED	SELECT PLAN:
		☐ CIGNA Dental Care* ☐ CIGNA Dental PPO ☐ CIGNA Traditional ☐ CIGNA VisionCare *In Illinois this refers to the DHMO

EMPLOYEE IDENTIFICATION NUMBER *(if applicable)*	CIGNA DENTAL HEALTH GROUP #	DIVISION / CLASS / LOCATION	CONNECTICUT GENERAL GROUP # *(if applicable)*

Please submit proof of student or handicapped status for overage dependents.
The original effective date must be completed for each member in order for continuous coverage credit to be applied toward waiting period.

DO YOU HAVE A DISABILITY AFFECTING YOUR ABILITY TO COMMUNICATE OR READ? *(optional)* ☐ Yes ☐ No

COMPLETE FOR ALL PERSONS TO BE COVERED

RELATION-SHIP	NAME *(include last name if different)*	SOCIAL SECURITY NUMBER	ADDRESS *(if different)*	SEX	DATE OF BIRTH *(Month, Day, Year)*	DENTAL OFFICE SELECTION *(for CIGNA Dental Care only)* 1st Choice	DENTAL OFFICE SELECTION *(for CIGNA Dental Care only)* 2nd Choice	START DATE OF CONTINUOUS DENTAL COVERAGE *(for CIGNA Dental PPO only)* *(Month, Day, Year)*	*(check one)*
Self		- -		☐ M ☐ F					☐ Add ☐ Cancel
Spouse		- -		☐ M ☐ F					☐ Add ☐ Cancel
Child		- -		☐ M ☐ F					☐ Add ☐ Cancel
Child		- -		☐ M ☐ F					☐ Add ☐ Cancel
Child		- -		☐ M ☐ F					☐ Add ☐ Cancel

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 dependents to CIGNA Dental Health and Connecticut General Life Insurance Company for purposes of plan administration or for the purpose of validating and determining benefits payable. I further authorize CIGNA Dental Health and Connecticut General Life Insurance Company to release any records or information concerning me or my 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 Dental Health and Connecticut General Life Insurance Company do not require such tests in any state as a condition of obtaining dental coverage.

I have read and accept the provisions printed above:	SIGNATURE	DATE

CIGNA Dental refers to the following operating subsidiaries of CIGNA Corporation: Connecticut General Life Insurance Company and CIGNA Dental Health, Inc., and its operating subsidiaries and affiliates. The CIGNA Dental Care plan is provided by CIGNA Dental Health Plan of Arizona, Inc., CIGNA Dental Health of California, Inc., CIGNA HealthCare of Colorado, Inc., CIGNA Dental Health of Connecticut, 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 Illinois, 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 Connecticut General Life Insurance Company and administered by CIGNA Dental Health, Inc. The CIGNA Dental PPO is underwritten or administered by Connecticut General Life Insurance Company with network management services provided by CIGNA Dental Health, Inc., and certain of its operating subsidiaries. The CIGNA Traditional and CIGNA VisionCare plans are underwritten or administered by Connecticut General Life Insurance Company.

DISTRIBUTION: White - CIGNA **Canary -** Member