Employer: Complete Section A Employee Complete Sections B-F

Administered by Cigna Health and Life Insurance Company

Enrollment/Change Form

A	◻ OPEN ENROLLMENT ◻ CHANGE ◻ NEW ENROLL ◻ REINSTATE	EFFECTIVE DATE OF ACTION ____/____/______	DATE OF QUALIFYING EVENT ____/____/______	EMPLOYER NAME Guild of St. Agnes	DATE OF HIRE ____/___/____	PLAN NUMBER 622568

B	◻ SINGLE ◻ MARRIED ____/___/____ ◻ SEPARATED ◻ DIVORCED/WIDOWED	TYPE OF CHANGE: ◻ Demographics ◻ PCP Change ◻ Retirement ◻ COBRA Continuation ◻ Add Dependent(s) *List Name(s) in Section C ◻ Other ________________

C

EMPLOYEE NAME (LAST)	(FIRST)	SOCIAL SECURITY NUMBER
EMPLOYEE DATE OF BIRTH	PHONE NUMBER	EMAIL ADDRESS

ADDRESS (STREET)	(CITY)	(STATE)	(ZIP CODE)

o YES, I WOULD LIKE COVERAGE FOR MYSLEF AND MY DEPENDENTS o I AM DECLINING COVERAGE

LAST NAME	FIRST NAME	RELATIONSHIP	SOCIAL SECURITY NUMBER	DATE OF BIRTH	GENDER	FULL TIME STUDENT?
					◻ Male ◻ Female	◻ Yes ◻ No
					◻ Male ◻ Female	◻ Yes ◻ No
					◻ Male ◻ Female	◻ Yes ◻ No
					◻ Male ◻ Female	◻ Yes ◻ No
					◻ Male ◻ Female	◻ Yes ◻ No
					◻ Male ◻ Female	◻ Yes ◻ No

***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 requested for dental and/or vision coverage if available.*

D

MEDICAL OPTIONS:

◻ Cigna Local Plan Plus HRA Deductibles: Individual $4,000.00 / Family $8,000.00

◻ Cigna Open Access Plus / OAP in HRA Deductibles: Individual $4,000.00 / Family $8,000.00

E

OTHER HEALTHCARE COVERAGE: Do you or your dependents have other health insurance under a group plan, HOM or Medicare? ◻ No ◻ Yes - Complete Following:

NAME OF PERSON COVERED	SOCIAL SECURITY NUMBER	MEDICARE	MEDICAID	OTHER INSURANCE	EFFECTIVE DATE
		◻ Part A ◻ Part B			
		◻ Part A ◻ Part B			
		◻ Part A ◻ Part B			

F

The information provided above is true and correct to the best of my knowledge. 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 and understand the disclosure in this Enrollment / Change form. I authorize the required payroll deduction for the contributory benefits. I understand that I will not be individually denied coverage nor be charged a different rate as a result of my answers. However, if I knowingly provide false information, I understand and agree that it may affect the payment of claims and/or result in termination of my or my dependent(s) coverage.**

EMPLOYEE SIGNATURE / DATE