Cigna Dental Enrollment Form

Insured and/or Administered by
Cigna Health and Life Insurance Company

Cigna

Please print and thank you for providing this information

A

OPEN ENROLL. / NEW ENROLL. / CHANGE / REINSTATE	EFFECTIVE DATE OF ADD/CHANGE/ CANCELLATION (MM/DD/CCYY)	EMPLOYER NAME	EMPLOYER ADDRESS
		AMHERST EXEMPTED VILLAGE SCHOOLS	550 MILAN AVE, AMHERST, OH 44001

CIGNA ACCOUNT NO.	DIVISION/BRANCH/LOCATION/CLASS	DATE OF HIRE (MM/DD/CCYY)	NETWORK ID	BRANCH CODE	CDH GROUP NO.	DENTAL BENEFIT OPTION
3334826	☐ ADM ☐ CERT ☐ CLASS ☐ COBRA					

TYPE OF CHANGE:

- ☐ **Add Dependent(s) *** Date: _____
- ☐ **Cancel Employee** Last Date of Coverage: _____
- ☐ **Cancel Dependent(s) *** Last Date of Coverage: _____
  Reason for Cancellation:
  - ☐ Leave employment
  - ☐ Transfer out of Cigna Dental Care area
  - ☐ Transfer to another plan

*** List Names in Section C**

- ☐ **Address Change - enter new address in Section B below**
- ☐ **Transfer to COBRA - 18 MONTHS**
- ☐ **Other** _____

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)*
		OHIO	

WHAT IS YOUR PRIMARY LANGUAGE? *(optional)*	DO YOU HAVE A DISABILITY AFFECTING YOUR ABILITY TO COMMUNICATE OR READ? *(optional)*	SELECT PLAN:
	☐ Yes ☐ No	☐ Cigna Dental HMO ☐ Cigna Dental PPO

C

I WOULD LIKE COVERAGE FOR ME AND MY DEPENDENTS. *(Specify last name if different from yours)* Last Name / First Name / M.I.	DEPENDENT SOCIAL SECURITY NO.	DATE OF BIRTH MM DD CCYY	GENDER	FULL-TIME STUDENT? Yes No	DENTAL OFFICE SELECTION *(for Cigna Dental Care only)* HM	START DATE OF CONTINUOUS DENTAL COVERAGE *(for Cigna Dental PPO only)* *(Month, Day, Year)*	*(check one)*
Employee			☐ M ☐ F		1st Choice - 2nd Choice -		☐ Add ☐ Cancel
Spouse			☐ M ☐ F		1st Choice - 2nd Choice -		☐ Add ☐ Cancel
Dependent Relationship			☐ M ☐ F	☐ ☐	1st Choice - 2nd Choice -		☐ Add ☐ Cancel
Dependent Relationship			☐ M ☐ F	☐ ☐	1st Choice - 2nd Choice -		☐ Add ☐ Cancel
Dependent Relationship			☐ M ☐ F	☐ ☐	1st Choice - 2nd Choice -		☐ Add ☐ Cancel

Proof of student or handicapped status for overage 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.

D

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 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. By entering your name electronically on this form you are agreeing that your electronic signature is the legal equivalent of your manual signature (Board Policy 6107).

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. (Kentucky and Illinois), 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").