Administered by Cigna Health and Life Insurance Company

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

Enrollment/Change Form

A	☐ OPEN ENROLL ☐ CHANGE ☐ NEW ENROLL ☐ REINSTATE	EFFECTIVE DATE OF CHANGE ADD/CHANGE/CANCELLATION (MM/DD/CCYY) _____/_____/_____	EMPLOYER NAME Chayce Corp	DATE OF HIRE (MM/DD/CCYY) _____/_____/_____	PLAN NUMBER 619350	SUBGROUP	CLASS

B	☐ SINGLE ☐ MARRIED _____/_____/_____ ☐ SEPARATED ☐ DIVORCED ☐ WIDOWED	TYPE OF CHANGE ☐ Add Dependent(s) * ☐ Demographics ☐ PCP Change ☐ Retirement * List Name(s) in Section C ☐ COBRA Continuation ☐ Other ___________________________ Qualifying Event Date: _____/_____/_____

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	Height	Weight	Coverage Selection	Full-Time Student?	Please list PCP ID below**	Dental Late Entrant?			
Employee	- -	/ /	☐M ☐F			☐Med ☐Den ☐Vis	☐ Yes ☐ No		☐ Yes ☐ No			
Dependent Relationship	- -	/ /	☐M ☐F			☐Med ☐Den ☐Vis	☐ Yes ☐ No		☐ Yes ☐ No			
Dependent Relationship	- -	/ /	☐M ☐F			☐Med ☐Den ☐Vis	☐ Yes ☐ No		☐ Yes ☐ No			
Dependent Relationship	- -	/ /	☐M ☐F			☐Med ☐Den ☐Vis	☐ Yes ☐ No		☐ Yes ☐ No			
Dependent Relationship	- -	/ /	☐M ☐F			☐Med ☐Den ☐Vis	☐ Yes ☐ No		☐ 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 required for dental and/or vision coverage. **PCP ID is required when the Medical Option selected below is Cigna SureFit®. If a PCP is not selected during enrollment one will be assigned. Otherwise PCP is optional.

D

	MEDICAL OPTIONS:	
☐	HSA (with Banking)/ Cigna HSA	
☐	Open Access Plus/ Cigna OAP Base	
☐	Open Access Plus/ Cigna OAP Buy Up	
☐	Decline Coverage	

E

	DENTAL OPTIONS:		VISION OPTIONS:
☐	Cigna Dental Traditional/ Cigna Dental HMO	☐	Cigna Vision/Cigna Vision
☐	Cigna Dental PPO/ Cigna DPPO Base		
☐	Cigna Dental PPO/ Cigna DPPO Buy Up		
☐	Decline Coverage	☐	Decline Coverage

F 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
	- -	_____/_____/_____	☐	☐	☐	
	- -	_____/_____/_____	☐	☐	☐	

G	
	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