BENEFIT ENROLLMENT • CHANGE FORM

Company Name

Date of Hire Needed for Eligibility Purposes DOH (MM/DD/YYYY) _____

Name (First, Middle, Last)	Email	
Address (Street, City, State, Zip Code)	Social Security # – – DOB (MM/DD/YYYY)	☐ Male ☐ Single ☐ Female ☐ Married
Home Phone Number Work Phone Number	Medicare Eligible: ☐ Yes ☐ No Medicare ID:	

Coverage Effective Date (MM/DD/YYYY)	☐ COBRA Continuation (MM/DD/YYYY)

Medical Plan: Please select your level of coverage and the Plan ☐ Employee Only ☐ Employee + Child(ren) ☐ Employee + Spouse ☐ Employee + Spouse + Child(ren)

Plan Election: ☐ EPO ☐ POS ☐ MEC ☐ MVP Type in Plan Name: (ex. POS EXEC) _____

Spouse Name (First, Middle, Last)	Spouse Social Security # - -	Spouse DOB (MM/DD/YYYY)

Spouse Medicare Eligible Yes ☐ No ☐ Spouse Medicare Enrolled Yes ☐ No ☐ Medicare ID:

Health Savings Account Eligible: Value Plan

Yes ☐ Annual Amount (Applied Monthly):_____

Flex Spending Account (Medical, Dental, Vision Expenditures*)

Yes ☐ Annual Amount (Applied Monthly):_____

Term Life and Accidental Death & Dismemberment (AD&D) Insurance

☐ Life/AD&D Elective (All Cigna Enrollees receive $10,000 of Life Coverage, please indicate the additional election amount) Amount:_____

☐ Spouse Life/AD&D Elective Amount:_____

☐ Child Life Elective ($5,000, $10,000, $15,000, $20,000) Amount:_____

Individual Life Insurance Application (Up to $200,000 non-medical available) ☐

Transit/Parking Pre-Tax Withholding

Yes ☐ Transit Amount (Monthly):_____ Parking Amount (Monthly):_____

Medical Bridge

Yes I elect the Medical Bridge ☐

Disability Insurance Income

☐ STD Benefit ☐ LTD Benefit Job Title: Income:

LTD Monthly Coverage Amount Requested(60% or 15,000 max): _____ STD:_____

Check here if you would like to request information on an Individual DI policy (group discounts apply) ☐

Dental & Vision Insurance

Dental level of coverage

☐ Employee Only
☐ Employee + Spouse
☐ Employee + Child(ren)
☐ Employee + Spouse + Child(ren)

Guardian PPO 1500 ☐
Guardian PPO 2000 ☐
Guardian HMO ☐

Vision level of coverage

☐ Employee Only
☐ Employee + Spouse
☐ Employee + Child(ren)
☐ Employee + Spouse + Child(ren)

NOTE: Your Employer is not responsible for any elective benefits you apply for nor any personal insurance products you request. Upon termination of employment elective benefits will not continue to be available unless an employee elects to transfer benefits, Your Employer will not be responsible to transfer any benefits.

* A Health Care FSA can be used to reimburse medical and dental expenses that qualify as federal income tax deductions (whether or not they exceed the IRS minimum applied to these deductions) under Section 213 of the tax code. Medical expenses that are not deductible under Section 213 may not be reimbursed by a health FSA. Expenses may be incurred by the employee or by the employee's spouse or eligible dependents (children, siblings, parents and others for whom an exemption may be claimed under Section 152 of the tax code). **Important Note for FSA Account Election: If you terminate employment at with your company you will be financially responsible for any funds that have not been collected via payroll. Example: $50/mo $600/annual election. If you terminate employment after two (2) months, you will be responsible for $500 to your employer.**

Dependent Information

If you are applying for coverage for your **Child** and/or Child(ren), please provide the information requested below:

Name(s) of your Child(ren) (First, Middle, Last)	DOB/SSN	
		☐ Male ☐ Female
		☐ Male ☐ Female
		☐ Male ☐ Female
		☐ Male ☐ Female
		☐ Male ☐ Female
		☐ Male ☐ Female

☐ Check here if you need more lines. Provide the additional information on a separate piece of paper and return it with your enrollment form.

FRAUD WARNINGS

Before signing this enrollment form, please read the warning for the state where you reside and for the state where the insurance policy under which you are applying for coverage was issued.

Arkansas, District of Columbia, Louisiana, Massachusetts, New Mexico, Ohio, Rhode Island and West Virginia: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Colorado: It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

Florida: A person who knowingly and with intent to injure, defraud or deceive any insurance company files a statement of claim or an application containing false, incomplete or misleading information is guilty of a felony of the third degree.

Kentucky: Any person who knowingly and with intent to defraud any insurance company or other person files an application 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.

Maine, Tennessee, Virginia and Washington: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purposes of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

Maryland: Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

New Jersey: Any person who files an application containing any false or misleading information is subject to criminal and civil penalties.

New York: [only applies to Accident and Health Benefits (AD&D/Disability/Dental)]: 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 civil penalty not to exceed five thousand dollars and the stated value of the claim for each violation.

Oklahoma: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

Oregon and Vermont: Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

Puerto Rico: Any person who knowingly and with the intention to defraud includes false information in an application for insurance or files, assists or abets in the filing of a fraudulent claim to obtain payment of a loss or other benefit, or files more than one claim for the same loss or damage, commits a felony and if found guilty shall be punished for each violation with a fine of no less than five thousand dollars ($5,000), not to exceed ten thousand dollars ($10,000); or imprisoned for a fixed term of three (3) years, or both. If aggravating circumstances exist, the fixed jail term may be increased to a maximum of five (5) years; and if mitigating circumstances are present, the jail term may be reduced to a minimum of two (2) years.

Pennsylvania and all other states: 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 subjects such person to criminal and civil penalties.

BENEFICIARY DESIGNATION FOR EMPLOYEE INSURANCE

Note: Dependent insurance is payable to the Employee.
If you have previously designated a beneficiary under this Group Customer's plan, such beneficiary designation will remain in effect. Any Principal payment upon your death will be paid in accordance with the records of the recordkeeper for such insurance unless you designate a beneficiary below. I designate the following person(s) as primary beneficiary(ies) for any Principal payment upon my death.
I understand I have the right to change this designation at any time.

Primary Beneficiary Full Name (Last, First, Middle Initial)	Relationship	Date of Birth (MM/DD/YYYY)	Address (Street, City, State, Zip Code)	Share %
Unless otherwise indicated, payment will be made in equal shares to your surviving Primary Beneficiary(ies).			TOTAL:	100%
If all of the Primary Beneficiary(ies) die before me, I designate as Contingent Beneficiary(ies):				
Contingent Beneficiary Full Name (Last, First, Middle Initial)	Relationship	Date of Birth (MM/DD/YYYY)	Address (Street, City, State, Zip Code)	Share %
Unless otherwise indicated, payment will be made in equal shares to your surviving Contingent Beneficiary(ies).			TOTAL:	100%

DECLARATIONS AND SIGNATURE

By signing below, I acknowledge:

1. I have read this enrollment form and declare that all information I have given is true and complete to the best of my knowledge and belief.
2. I declare that I am actively at work on the date I am enrolling and, if I am enrolling for any contributory life insurance, that I was actively at work for at least 20 hours during the 7 calendar days preceding my date of enrollment. I understand that if I am not actively at work on the scheduled effective date of insurance, such insurance will not take effect until I return to active work.
3. I understand that, on the date dependent insurance for a person is scheduled to take effect, the dependent must not be confined at home under a physician's care, receiving or applying for disability benefits from any source, or Hospitalized. If the dependent does not meet this requirement on such date, the insurance will take effect on the date the dependent is no longer confined, receiving or applying for disability benefits from any source, or Hospitalized.
4. I understand that if I do not enroll for life or disability coverage during the initial enrollment period, or if I do not enroll for the maximum amount of coverage for which I am eligible, evidence of insurability satisfactory to the insurance carrier may be required to enroll for or increase such coverage after the initial enrollment period has expired. Coverage will not take effect, or it will be limited, until notice is received that the carrier has approved the coverage or increase. I also understand that if I do not enroll for coverage during the initial enrollment period, a waiting period may be required before I can enroll for such coverage after the initial enrollment period has expired.
5. I authorize my employer to deduct the required contributions from my earnings for my coverage. This authorization applies to such coverage until I rescind it in writing.
6. I affirmatively decline coverage for any benefits for which I am eligible which I do not request on this enrollment form.
7. I have read the Beneficiary Designation section provided in this enrollment form and I have made a designation if I so choose.
8. I have read the applicable Fraud Warning(s) provided in this enrollment form.

Signature of Employee	Print Name	Date Signed (MM/DD/YYYY)