

CIGNA HEALTHCARE ENROLLMENT / CHANGE FORM (CONSOLIDATED) FOR WILSON COUNTY, TN SCHOOLS

Employer: Complete Section A
Employee: Complete Sections B-D

A	Open Enroll <input type="checkbox"/> Change <input type="checkbox"/> New Enroll <input type="checkbox"/> Reinstate <input type="checkbox"/>		EFFECTIVE DATE	Employer Name WILSON COUNTY BOARD OF EDUCATION	Employer Address 351 STUMPY LN., LEBANON, TN 37090
	CIGNA Account Number 3329405	Date of Hire	Branch CERTIFIED <input type="checkbox"/> CLASSIFIED <input type="checkbox"/>	Medical Benefit Option OAP	Dental Benefit Option DPPO
	TYPE OF CHANGE: Add Dependent(s) ___ Cancel Employee ___ Cancel Dependent(s) ___				

B	Employee Name (Last) _____ (First) _____ (MI) _____			Social Security Number _____				
	Employee Date of Birth	Home Phone (with area code)	Employee ID Number	Marital Status: Married ___ Single ___				
	Address (Street) _____		(City) _____	(State) _____	(Zip Code) _____			
	I WOULD LIKE COVERAGE FOR ME AND MY DEPENDENTS (LIST ANY DEPENDENTS YOU WISH TO ADD OR CANCEL		Dependent Social Security Number	Date of Birth	Gender M/F	Coverge Selection	Add or Cancel	Full Time Student?
	(Last) _____ (First) _____ (MI) _____							
	Employee				M <input type="checkbox"/> F <input type="checkbox"/>	Medical <input type="checkbox"/> Dental <input type="checkbox"/>	Add <input type="checkbox"/> Cancel <input type="checkbox"/> Decline <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>
Spouse				M <input type="checkbox"/> F <input type="checkbox"/>	Medical <input type="checkbox"/> Dental <input type="checkbox"/>	Add <input type="checkbox"/> Cancel <input type="checkbox"/> Decline <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	
Dependent*				M <input type="checkbox"/> F <input type="checkbox"/>	Medical <input type="checkbox"/> Dental <input type="checkbox"/>	Add <input type="checkbox"/> Cancel <input type="checkbox"/> Decline <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	
Dependent*				M <input type="checkbox"/> F <input type="checkbox"/>	Medical <input type="checkbox"/> Dental <input type="checkbox"/>	Add <input type="checkbox"/> Cancel <input type="checkbox"/> Decline <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	
Dependent*				M <input type="checkbox"/> F <input type="checkbox"/>	Medical <input type="checkbox"/> Dental <input type="checkbox"/>	Add <input type="checkbox"/> Cancel <input type="checkbox"/> Decline <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	
*Dependents - Up to age 24 if child remains unmarried and a dependent of the employee. If total disabled prior to age 24, attach proof of disability for review.								

C	OTHER HEALTHCARE COVERAGE - PLEASE COMPLETE IF YOU WILL BE COVERED UNDER ANOTHER PLAN AS OF YOUR EFFECTIVE DATE:					
	NAME OF PERSON COVERED	SOCIAL SECURITY NUMBER	EFFECTIVE DATE	MEDICARE COVERAGE Part A <input type="checkbox"/> Part B <input type="checkbox"/>	MEDICAID <input type="checkbox"/>	OTHER CARRIER

D	SIGNATURE - The information provided above is true and correct to the best of my knowledge, and I accept the provisions below, which I have read and understand.	
	Employee's Signature / Date	Employer's Signature / Date

PROVISIONS: Cigna HealthCare refers to various operating subsidiaries of Cigna Corporation. Products and services are provided by these subsidiaries and are not by CIGNA Corporation. These subsidiaries include Connecticut General Life Insurance Company, Tel-Drug, Inc. and its affiliates, CIGNA Behavioral Health, Inc, Intracorp, and HMO or service company subsidiaries of CIGNA Health Corporation and CIGNA Dental Health, Inc. I agree, for myself and my dependents, that, in the event any health services provided are the primary responsibility of any other party by way of other group health coverage or by the act or omission of another person to fully inform the healthplan and will execute such assignments, liens or other documents which may be necessary to enable the healthplan to recover the value of the services provided. I further agree that in the event I or any of my dependents collect benefits or damages from any other party who has primary responsibility for services provided by the healthplan, I will immediately reimburse the healthplan to the extent of services provided, to the extent permitted by state law.

FRAUD WARNING: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

AUTHORIZATION TO DEDUCT CONTRIBUTIONS: I authorize deductions from my earnings of the required contributions, if any, toward the cost of the coverage. This authorization applies only if employee contributions are required.