Enrollment / Change Form (Consolidated)

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

Insured and/or Administered by
Connecticut General Life Insurance Company

CIGNA HealthCare of California, Inc.

Please print and thank you for providing this information

A

[X] OPEN ENROLL. [ ] CHANGE [ ] NEW ENROLL. [ ] REINSTATE	EFFECTIVE DATE OF ADD/CHANGE/ CANCELLATION (MM/DD/CCYY) 12/01/2009	EMPLOYER NAME WECA	EMPLOYER ADDRESS 9719 Lincoln Village Drive, #303, Sacramento, CA

CIGNA ACCOUNT NO.	DIVISION/BRANCH/LOCATION/CLASS	DATE OF HIRE (MM/DD/CCYY)	NETWORK ID	BRANCH CODE	CDH GROUP NO.	MEDICAL BEN. OPTION	DENTAL BEN. OPTION	CIGNA CHOICE FUND ANNUAL AMOUNT
3332363								

TYPE OF CHANGE:
- [ ] Add Dependent(s) * Date: ____
- [ ] Cancel Employee Last Date of Coverage: ____
- [ ] Cancel Dependent(s) * Last Date of Coverage: ____
- * List Names in Section B
- [ ] Address Change
- [ ] Transfer to COBRA [ ] 18 mos. [ ] 29 mos. [ ] 36 mos.
- [ ] Family Security Benefit/Surviving Spouse
- [ ] Retirement
- [ ] 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)

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	COVERAGE SELECTION	FULL TIME STUDENT? * Yes No	If you choose a Managed Care Medical Option: Select your choice of Primary Care Physician (PCP) or HealthCare Center (HCC) and enter the ID Numbers below. Note: PCP selection is optional for Open Access Plans.	EXISTING PATIENT? Yes No	If you choose the CIGNA Dental Care Option: Enter your 1st and 2nd choice of Dental Office Number below.	EXISTING PATIENT? Yes No	(check one)
Employee			[ ] M [ ] F	[ ] Medical [ ] Dental		PCP or HCC Choice -	[ ] [ ]	1st Choice - 2nd Choice -	[ ] [ ] [ ] [ ]	[ ] Add [ ] Cancel
Spouse			[ ] M [ ] F	[ ] Medical [ ] Dental		PCP or HCC Choice -	[ ] [ ]	1st Choice - 2nd Choice -	[ ] [ ] [ ] [ ]	[ ] Add [ ] Cancel
Dependent * Relationship			[ ] M [ ] F	[ ] Medical [ ] Dental	[ ] [ ]	PCP or HCC Choice -	[ ] [ ]	1st Choice - 2nd Choice -	[ ] [ ] [ ] [ ]	[ ] Add [ ] Cancel
Dependent * Relationship			[ ] M [ ] F	[ ] Medical [ ] Dental	[ ] [ ]	PCP or HCC Choice -	[ ] [ ]	1st Choice - 2nd Choice -	[ ] [ ] [ ] [ ]	[ ] Add [ ] Cancel
Dependent * Relationship			[ ] M [ ] F	[ ] Medical [ ] Dental	[ ] [ ]	PCP or HCC Choice -	[ ] [ ]	1st Choice - 2nd Choice -	[ ] [ ] [ ] [ ]	[ ] Add [ ] Cancel

***DEPENDENTS** - If full time student and age 19 or over, attach proof verifying credit hours. If totally disabled prior to age 19, attach proof of disability for eligibility review.

C

MANAGED CARE MEDICAL OPTIONS:
- [ ] Point-of-Service (or DPP or CHA)
- [ ] HMO
- [ ] Network (or EPP)
- [ ] Point-of-Service Open Access
- [ ] HMO Open Access
- [ ] Network Open Access
- [ ] Open Access Plus
- [X] Open Access Plus In-Network

OTHER MEDICAL OPTIONS:
- [ ] Preferred Provider Option (PPO)
- [ ] In-Network PPO or EPO
- [ ] Preferred Provider Access (PPA)
- [ ] Medical Indemnity
- [ ] ____

CIGNA CHOICE FUND℠ OPTIONS:
- [ ] HRA
- [ ] HSA
- [ ] Pharmacy HRA
- [ ] Dental HRA
- [ ] with PPO
- [ ] with Open Access Plus
- [ ] with Open Access Plus In-Network
- [ ] with EPO
- [ ] with Indemnity

- [ ] CIGNA Care Network
- [ ] Decline Coverage

OPTION # (if applicable): [ ] 1 [ ] 2 [ ] 3

If you choose a Managed Care Medical Option other than Open Access Plus, print the name of the CIGNA HealthCare network. (See the cover or first page of the physician directory). Include the name of the city and state. CIGNA HealthCare of (city/state):

D **FLEXIBLE SPENDING ACCOUNT OPTIONS:**
- [ ] Health Care*
- [ ] Dependent Day Care*
- [ ] Decline Coverage

E **DENTAL OPTIONS:**
- [ ] CIGNA Dental Care (CDC)
- [ ] Dental PPO
- [ ] Dental EPO
- [ ] Dental Indemnity
- [ ] Decline Coverage

*If you have checked off one of the Flexible Spending Accounts in Section D, please make sure you have completed the corresponding enrollment form included in this package.

F **OTHER HEALTH CARE 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 NO.	EFFECTIVE DATE	MEDICARE Part A	MEDICARE Part B	MEDICAID	OTHER INSURANCE CARRIER
			[ ]	[ ]	[ ]	[ ]
			[ ]	[ ]	[ ]	[ ]

G **CALIFORNIA RESIDENTS ONLY:** CIGNA HealthCare uses binding arbitration to settle disputes, including claims of medical malpractice and disputes relating to the delivery of service under the plan. It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review or arbitration proceedings. The parties to this contract, by entering into it, are giving up their constitutional right to have any dispute decided in a court of law before a jury, and instead are accepting the use of arbitration. It is understood that this agreement to arbitrate shall apply and extend to any dispute for medical malpractice, relating to the delivery of service under the plan, and to any claims in tort, contract or otherwise, between Group, any individual(s) seeking services under the plan, whether referred to as a Member, Subscriber, Dependent, Enrollee or otherwise (whether a minor or an adult), or the heirs-at-law or personal representatives of any such individual(s), as the case may be, and CIGNA Healthcare (including any of their agents, successors- or predecessors-in-interest, employees, or providers).

H **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	SPOUSE'S SIGNATURE / DATE	EMPLOYER'S SIGNATURE / DATE