

Enrollment / Change Form (Consolidated)

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

Please print and thank you for providing this information

Insured and/or Administered by
Connecticut General Life Insurance Company
CIGNA HealthCare



A

OPEN ENROLL CHANGE EFFECTIVE DATE OF ADD/CHANGE/ CANCELLATION (MM/DD/CCYY)

NEW ENROLL REINSTATE

EMPLOYER NAME: **WECA**

EMPLOYEE ACCOUNT NO.: **3332363** DIVISION/BRANCH/LOCATION/CLASS: _____ DATE OF HIRE (MM/DD/CCYY): _____

EMPLOYEE ADDRESS: **9719 Lincoln Village Drive #303 Sacramento, CA 95827**

NETWORK ID: _____ BRANCH CODE: _____ CDH GROUP NO.: _____ MEDICAL BEN. OPTION: _____ DENTAL BEN OPTION: _____ CIGNA CHOICE FUND ANNUAL AMOUNT: _____

TYPE OF CHANGE:

Add Dependent(s) * Date: _____ Address Change

Cancel Employee Last Date of Coverage: _____ Transfer to COBRA

Cancel Dependent(s) * Last Date of Coverage: _____ 18 mos. 29 mos. 36 mos.

Family Security Benefits/ Surviving Spouse

Retirement

Other _____

* List Names in Section B

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 _____

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.	DATE OF BIRTH (MM DD CCYY)	GEN. DER. COVERAGE SELECTION	FULL TIME STUDENT? * Yes No	EXISTING PATIENT? * Yes No	EXISTING PATIENT? * (check one)
Employee				<input checked="" type="checkbox"/> Medical <input type="checkbox"/> F <input type="checkbox"/> Denial			<input type="checkbox"/> Add <input type="checkbox"/> Cancel
Spouse				<input type="checkbox"/> Medical <input type="checkbox"/> F <input type="checkbox"/> Denial			<input type="checkbox"/> Add <input type="checkbox"/> Cancel
Dependent *				<input type="checkbox"/> Medical <input type="checkbox"/> F <input type="checkbox"/> Denial			<input type="checkbox"/> Add <input type="checkbox"/> Cancel
Dependent *				<input type="checkbox"/> Medical <input type="checkbox"/> F <input type="checkbox"/> Denial			<input type="checkbox"/> Add <input type="checkbox"/> Cancel
Dependent *				<input type="checkbox"/> Medical <input type="checkbox"/> F <input type="checkbox"/> Denial			<input type="checkbox"/> Add <input type="checkbox"/> 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

OTHER MEDICAL OPTIONS:

Preferred Provider Option (PPO) In-Network PPO or EPO Preferred Provider Access (PPA) Medical Indemnity

OTHER MEDICAL OPTIONS:

HMO Open Access Network Open Access Open Access Plus Open Access Plus In-Network

CIGNA CHOICE FUND OPTIONS:

HRA HSA Pharmacy HRA Denial HRA

with PPO with Open Access Plus with Open Access Plus In-Network with EPO with Indemnity

CIGNA CARE NETWORK Decline Coverage Decline Coverage

OPTION # (if applicable): 1 2 3

D FLEXIBLE SPENDING ACCOUNT OPTIONS:

Health Care * Dependent Day Care * Decline Coverage

E DENTAL OPTIONS:

CIGNA Denial Care (CDC) Dental PPO Dental EPO Dental Indemnity Decline Coverage

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 Part B MEDICAID OTHER INSURANCE CARRIER

G

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 _____ SPOUSES SIGNATURE / DATE _____ EMPLOYERS SIGNATURE / DATE _____