Enrollment / Change Form (Consolidated)

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

Please print and thank you for providing this information

Insured and/or Administered by
Cigna Health and Life Insurance Company
Cigna HealthCare of California, Inc.

Cigna

A

☐ OPEN ENROLL. ☐ CHANGE
☐ NEW ENROLL. ☐ REINSTATE

EFFECTIVE DATE OF ADD/CHANGE/ CANCELLATION (MM/DD/CCYY)	EMPLOYER NAME	EMPLOYER ADDRESS
04/01/2018	CITY OF FULLERTON	303 W. Commonwealth Ave, Fullerton, CA 92832

CIGNA ACCOUNT NO.	DIVISION/BRANCH/LOCATION/CLASS	DATE OF HIRE (MM/DD/CCYY)	BRANCH CODE	MEDICAL BEN. OPTION	CIGNA CHOICE FUND ANNUAL AMOUNT
3330495					

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.
☐ 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

MAILING 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	GEN-DER	COVERAGE SELECTION	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	(check one)
Employee			☐ M ☐ F	☐ Med.	PCP or HCC Choice -	☐ ☐	☐ Add ☐ Cancel
Spouse			☐ M ☐ F	☐ Med.	PCP or HCC Choice -	☐ ☐	☐ Add ☐ Cancel
Dependent * Relationship			☐ M ☐ F	☐ Med.	PCP or HCC Choice -	☐ ☐	☐ Add ☐ Cancel
Dependent * Relationship			☐ M ☐ F	☐ Med.	PCP or HCC Choice -	☐ ☐	☐ Add ☐ Cancel
Dependent * Relationship			☐ M ☐ F	☐ Med.	PCP or HCC Choice -	☐ ☐	☐ Add ☐ Cancel

*DEPENDENTS - Dependents are covered under the medical plan to age 26.

C

MANAGED CARE MEDICAL OPTIONS:

☐ HMO FULL NETWORK PLAN

OTHER MEDICAL OPTIONS:

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

☐ Decline Coverage

OPTION # (if applicable): ☐ 1 ☐ 2 ☐ 3

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

Cigna HealthCare of (city/state):

*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.

D

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	MEDICARE ID #	MEDICAID	OTHER INSURANCE CARRIER
			☐	☐		☐	☐
			☐	☐		☐	☐

E

CALIFORNIA RESIDENTS ONLY: Cigna Health and Life Insurance Company, Cigna HealthCare of California, Inc. and Cigna Dental Health, Inc. and its subsidiaries use 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 Health and Life Insurance Company, Cigna HealthCare of California, Inc., Cigna Dental Health, Inc. and its subsidiaries (including any of their agents, successors or predecessors-in-interest, employees, or providers).

F

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

PROVISIONS

- In California, HMO and Network plans are offered by Cigna HealthCare of California, Inc.
- In California, the DHMO (Cigna Dental Care) plan is underwritten or administered by Cigna Dental Health of California, Inc. The Cigna Dental PPO and Traditional plans are underwritten or administered by Cigna Health and Life Insurance Company, with network management services provided by Cigna Dental Health, Inc.
- I agree, for myself and my covered 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, I will fully inform the health plan and will execute such assignments, liens or other documents which may be necessary to enable the health plan to recover the value of the services provided. I further agree that in the event I or any of my covered dependents collect benefits or damages from any other party who has primary responsibility for services provided by the health plan, I will immediately reimburse the health plan to the extent of services provided and to the extent permitted by state law.

FRAUD WARNING

Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

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.

SPECIAL PROVISIONS FOR EMPLOYERS WITH SECTION 125 PLANS

By allowing an individual to enroll in the health plan, other than during the open enrollment period, Cigna Health and Life Insurance Company and its affiliates do not waive any terms of its contract. Further, by allowing an individual to enroll in the health plan, other than during an open enrollment period, Cigna Health and Life Insurance Company and its affiliates do not thereby express any opinion regarding the appropriateness of the change under Section 125 of the Internal Revenue Code or the terms of the employer’s Section 125 Plan.