

Enrollment / Change Form (Consolidated)

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

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



Please print and thank you for providing this information

A	<input type="checkbox"/> OPEN ENROLL <input type="checkbox"/> NEW ENROLL	<input type="checkbox"/> CHANGE <input type="checkbox"/> REINSTATE	EFFECTIVE DATE OF ADD/CHANGE/ CANCELLATION (MM/DD/CCYY) 04/01/2018	EMPLOYER NAME CITY OF FULLERTON	EMPLOYER ADDRESS 303 W. Commonwealth Ave, Fullerton, CA 92832	
	CIGNA ACCOUNT NO. 3330495	DIVISION/BRANCH/LOCATION/CLASS	DATE OF HIRE (MM/DD/CCYY)	BRANCH CODE	MEDICAL BEN. OPTION	CIGNA CHOICE FUND ANNUAL AMOUNT
TYPE OF CHANGE:						
<input type="checkbox"/> Add Dependent(s) *		Date: _____		<input type="checkbox"/> Address Change		
<input type="checkbox"/> Cancel Employee		Last Date of Coverage: _____		<input type="checkbox"/> Transfer to COBRA		<input type="checkbox"/> Retirement
<input type="checkbox"/> Cancel Dependent(s) *		Last Date of Coverage: _____		<input type="checkbox"/> 18 mos. <input type="checkbox"/> 29 mos. <input type="checkbox"/> 36 mos.		<input type="checkbox"/> 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 _____		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)		DEPENDENT SOCIAL SECURITY NO.	DATE OF BIRTH MM DD CCYY	GEN- DER	COVERAGE SELECTION	EXISTING PATIENT? Yes No	(check one)
	Last Name	First Name	M.I.					

Employee				<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Med.	PCP or HCC Choice -	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Add <input type="checkbox"/> Cancel
Spouse				<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Med.	PCP or HCC Choice -	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Add <input type="checkbox"/> Cancel
Dependent *	Relationship			<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Med.	PCP or HCC Choice -	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Add <input type="checkbox"/> Cancel
Dependent *	Relationship			<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Med.	PCP or HCC Choice -	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Add <input type="checkbox"/> Cancel
Dependent *	Relationship			<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Med.	PCP or HCC Choice -	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Add <input type="checkbox"/> Cancel

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

C	MANAGED CARE MEDICAL OPTIONS:	OTHER MEDICAL OPTIONS:	<input type="checkbox"/> Decline Coverage OPTION # (if applicable): <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3
	<input type="checkbox"/> HMO FULL NETWORK PLAN	<input type="checkbox"/> Preferred Provider Option (PPO) <input type="checkbox"/> In-Network PPO or EPO <input type="checkbox"/> Preferred Provider Access (PPA) <input type="checkbox"/> Medical Indemnity <input type="checkbox"/> HMO-Select	
If you choose a Managed Care Medical Option other than Open Access Plus/IN or LocalPlus/IN, 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.			

*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? <input type="checkbox"/> Yes <input type="checkbox"/> No		MEDICARE Part A		MEDICARE Part B		MEDI CAID		OTHER INSURANCE CARRIER	
	NAME OF PERSON COVERED	if yes, please provide the following: SOCIAL SECURITY NO.	EFFECTIVE DATE	<input type="checkbox"/>	<input type="checkbox"/>	MEDICARE ID #	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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 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.

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