Texas Employee Enrollment/Change of Coverage Form

(for groups with 2-50 employees)

Employee Social Security Number:	
Group Number: *(Existing CIGNA member)*	

Instructions: You, the employee, must complete this enrollment form in full to avoid in a delay in processing. You are solely responsible for its accuracy and completeness. **If waiving coverage, please enter your name, address and company name in Section 1 and Complete Section 4 only.**

SECTION 1 – Employee/Employer Information

Employee Name:		Employer Name / Location:			Date of Hire:
Employee Street Address, City, State and ZIP Code:		Employee Mailing Address, City, State and ZIP Code:			Home Phone No. Work Phone No:
Employment Status: ☐ Full-Time ☐ Temporary ☐ Other ☐ Part-Time ☐ Seasonal _____	Job Title:	# Hours Worked Per Week:	# Enrolling (including self):	Marital Status: ☐ Married ☐ Single	Proposed Effective Date:

Reason for Application: ☐ New Group Enrollment ☐ New Hire ☐ Late Enrollee ☐ Change of Coverage (existing insured only)	☐ Rehire ☐ Change of Address ☐ Name Change Only ☐ Add Dependents (Spouse/Dependent Child) ☐ COBRA or State Cont Enrollment	COBRA or State Continuation Original Qualifying Event Date: Reason: Length of Continuation: ☐ 18 months ☐ 36 months ☐ Other ____ months	

SECTION 2 – Plan Selection – Please indicate the plan and option your employer offers in which you are enrolling.

Note: You can only enroll in a plan your employer has selected to offer your group.

Open Access Plans	Health Savings Plans	PPO Plans
☐ OAP 500/80% ☐ OAP 2000/100%	☐ HSP 1500	☐ PPO Plan 1
☐ OAP 1000/80% ☐ OAP 3000/100%	☐ HSP 2500	☐ PPO Plan 2
☐ OAP 1500/80% ☐ OAP 5000/100%	☐ HSP 5000	
☐ OAP 2000/80%		

SECTION 3 – Complete for All Individuals to Be Covered (dependent children are covered to age 25)

Last Name	First Name	Sex M/F	Social Security Number	Date of Birth mm/dd/yyyy	Height; Ft./In.	Weight Lbs.	Disabled	Name of Primary Care Physician (PCP) (Optional for OAP Plans)	Current Patient?
Employee:							☐ Yes		☐ Yes
Spouse:							☐ Yes		☐ Yes
Child:							☐ Yes		☐ Yes
Child:							☐ Yes		☐ Yes
Child:							☐ Yes		☐ Yes

SECTION 4 – Waiver of Coverage – Only complete if waiving coverage for any reason.

I understand that I am eligible for the coverage being offered. However, I and/or the dependents listed below voluntarily waive the coverage. If coverage is waived, I am also stating the reasons why I/we are waiving coverage. (Please list names and indicate reasons below.)

☐ Employee	☐ Med	**Reason for waiving coverage:** ☐ Covered by Spouse's group coverage Provide Carrier Name and proof of other coverage _____ ☐ Enrolled in other Non-Group coverage: ☐ Medicare ☐ Retiree ☐ Military ☐ COBRA ☐ State Continuation ☐ Individual Private Insurance ☐ Other, list other Insurance Company Name _____ ☐ Other reason for waiving coverage _____
☐ Spouse	☐ Med	
☐ Child(ren):	☐ Med	

By waiving this coverage, I acknowledge that myself and/or dependent(s) may have to wait to enroll until the plan's next renewal date. Pre-Existing waiting periods and limitations may apply at the time of a future enrollment.

Sign here **only** if you are waiving coverage for yourself and/or dependents:	Date:

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SECTION 5 – Medical Questions

Health Questionnaire for all individuals enrolling (this includes employees, dependents and individuals on Cobra or State Continuation).

For any "Yes" answers in this section, details must be provided in Section (6) in order to process application.

5.1.	Has anyone listed on this enrollment form , within the last 5 years, been recommended treatment, sought treatment or continue to receive treatment for any condition?	☐ Yes ☐ No
5.2.	Has any individual listed on this enrollment form been recommended surgery for any condition?	☐ Yes ☐ No
5.3.	Is any individual listed on this enrollment form taking any prescription medications?	☐ Yes ☐ No
5.4.	Is anyone listed on this enrollment form currently pregnant? If so, please provide details such as type of delivery expected and whether multiple births are expected.	☐ Yes ☐ No

SECTION 6 – Health History Details – For all "Yes" answers provided in Section 5, provide full details below. If additional room is needed to provide details, attach a separate sheet of paper. Sign and date the additional sheet. Note: Incomplete answers may affect the final underwriting decision.

Name of Enrollee	Question Number	Name of Condition	Onset Date	Type of Treatment Received or Recommended	Treatment End Date	Name of Medication Prescribed	Dosage	Medication End Date or Ongoing

SECTION 7 – Other Coverage – Non completion of this section and failure to provide Proof of Prior Coverage may subject you and/or an enrolling family member to Pre-Existing waiting periods and limitations.

Does anyone enrolling on this form have current or prior coverage? ☐ Yes ☐ No If answered "Yes", complete section below and provide Proof of Prior Coverage.

Name:	Prior or Current Insurance Company Name:	Start Date:	End Date:	Currently On Medicare: ☐ Yes ☐ No If under age 65 and answered yes, please indicate reason.	List which part of Medicare (Parts A, B, D):

SECTION 8 – Dependent Information

☐ Does any dependent listed in Section 3 live at another address? ☐ Yes ☐ No

If answered "Yes," who and at what address: _____ _____.

☐ If any dependent's last name differs from yours, explain the circumstances: _____.

SECTION 9 – Authorization

- **Authorization to release medical records.** I authorize CIGNA to request my and/or my dependents' (those who are applying for coverage under this enrollment form) medical records, any prescribed medication history, and any other medical or pharmaceutical information to process my enrollment form. I authorize any health care provider, including hospitals, physicians, clinics, labs, pharmacies, pharmacy benefit managers or any other healthcare organizations or healthcare professionals that provided treatment or any other service to me and/or any of my dependents applying for coverage under this enrollment form to disclose to CIGNA the information required by CIGNA and described above. This authorization becomes effective immediately and shall remain in effect as long as necessary to permit evaluation of this application. I further agree that I or my dependents will sign any additional authorization form that may be required for release of such information.
- **Acknowledgment of key terms.** In completing this Application, I agree to the following for myself and all eligible dependents:

1. That any hospital, physician or other provider may furnish CIGNA medical information that may be required to conduct a utilization review program of health services, and to coordinate benefits and/or reimbursements with other health or insurance programs.
2. That all information furnished by me is true and complete to the best of my knowledge, and that I shall update the application with changes occurring between the date of this application and the first date of coverage, including new or changed medical conditions.
3. That any person who knowingly and with intent to defraud CIGNA or any other person files application for insurance or statement of claim containing any material false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act and may be subject to civil and criminal penalties.
4. That my employer's application will determine coverage and that I will not receive coverage until both this application and the employer's application have been accepted and approved by CIGNA.
5. That should I and my dependents be issued coverage, any dispute or claim shall be resolved according the grievance procedures contained in the Certificate of Coverage issued by CIGNA to enrollees.
6. That should I and my dependents be issued coverage, there may be a waiting period before pre-existing health conditions of me or my dependents are covered, as further explained in the Certificate of Coverage issued by CIGNA to enrollees.
7. That should I or my dependents be issued coverage and CIGNA provides health services that are the primary responsibility of Medicare, workers' compensation coverage, automobile medical payment coverage, or other payments source CIGNA may be authorized by law to pursue, we shall inform CIGNA of the other source of payment and execute such documents and provide such assistance as may be necessary to enable CIGNA to recover the value of services provided, arranged or covered.
8. That I am entitled upon request to a copy of this application, including the authorizations and acknowledgements made by me herein.
9. If a social security number is not provided on this application, CIGNA will issue a CIGNA assigned identification number to identify our plan members. Risks associated with the use of an assigned identification number include the following:
   a. The possibility exists that the assigned identification number may match another individual's Social Security number or an assigned identification number issued by another company.
   b. Use of an assigned identification number does not eliminate the possibility that another individual will access or misuse information related to that number.

Employee Signature:	Today's Date:

- Please keep a copy of this application for your records.
- NOTE: If there are any modifications to the statements and responses provided in this application (i.e. crossed out, white-out, erased information), the applicant must attest to the modifications by providing a complete signature in the margin near the modification.