

# Enrollment / Change Form

# SCHOOLCARE



<b>A</b>	<input type="checkbox"/> Open Enrollment	Hire Date	Effective Date	Employer Name	Employer Address	
	Account Number <b>3206140</b>	<input type="checkbox"/> Active	<input type="checkbox"/> Retiree	<input type="checkbox"/> COBRA	Branch Code	Billing Group
Type of change <input type="checkbox"/> Add Dependent(s): List names in Section B <input type="checkbox"/> Cancel Employee: _____ <input type="checkbox"/> Cancel Dependent(s): _____						
<input type="checkbox"/> Address Change <input type="checkbox"/> Transfer to COBRA <input type="checkbox"/> 18 mos. <input type="checkbox"/> 29 mos. <input type="checkbox"/> 36 mos.						
<input type="checkbox"/> Family Security Benefit/Surviving Spouse <input type="checkbox"/> Retirement <input type="checkbox"/> Other _____						
*Qualifying Event						

<b>B</b>	Employee Name <i>(last)</i>			<i>(first)</i>			<i>(M.I.)</i>			Social Security No.
	Home Phone			Work Phone			Home E-Mail Address (optional)			
	Mailing Address			<i>(City)</i>			<i>(State)</i>			<i>(Zip Code)</i>
	Last Name	First Name	M.I.	Medical	Dental	Dependent SS#	Date of Birth	Gender	PCP Name and PCP ID Number**	Existing Patient
										Yes No
	Employee							<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> <input type="checkbox"/>
Spouse (whom you wish to cover)							<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> <input type="checkbox"/>	
Dependent (whom you wish to cover)							<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> <input type="checkbox"/>	
Dependent (whom you wish to cover)							<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> <input type="checkbox"/>	
Dependent (whom you wish to cover)							<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> <input type="checkbox"/>	

<b>C</b>	<input type="checkbox"/> Dental _____ (insert plan code)	Coverage Options	If declining coverage please mark the box below. <input type="checkbox"/> Decline Medical Coverage <input type="checkbox"/> Decline Dental Coverage
	<input type="checkbox"/> HMO		
	<input type="checkbox"/> POS ** (PCP number not required for this plan)		
	<input type="checkbox"/> Open Access+** (PCP number not required for this plan)		

<b>D</b>	Other Health Care Coverage						
	Do you or your dependents have other health insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No						
	If yes and have elected SchoolCare coverage, please provide the other health plan information :						
	Name of person covered	ID Number or Medicare No.	Effective Date and Name of Carrier	Medicare Part A	Other Medicare Part B	Medicaid	Insurance Carrier
1.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
2.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Signature – The information provided above is true and correct to the best of my knowledge.	
E Employee's Signature/ Date	Employer's Signature / Date

**Please make a copy for both employee and employer then submit the original to SchoolCare.  
Please review additional information on reverse side of this form.**

**\* For a qualifying event, subscribers and dependents are allowed to join the plan within 30 days of the change.**

**Examples are:**

**Marriage**  
**Divorce**  
**Birth of a child**  
**Loss of other insurance through spouse**  
**Death**  
**Adoption**

#### **CIGNA HealthCare Provisions**

- "CIGNA HealthCare" refers to various operating subsidiaries of CIGNA Corporation. Products and services provided by these subsidiaries and not by CIGNA Corporation. These subsidiaries include Connecticut General Life Insurance Company, Tel-Drug, Inc. and its affiliates, CIGNA Behavioral Health, Inc., Intracorp, and HMO or service company subsidiaries of CIGNA Health Corporation and CIGNA Dental Health, Inc.
- I agree, for myself and my 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 to fully inform the healthplan and will execute such assignments, liens or other documents which may be necessary to enable the healthplan to recover the value of the services provided. I further agree that in the event I or any of my dependents collect benefits or damages from any other party who has primary responsibility for services provided by SchoolCare, I will immediately reimburse SchoolCare to the extent of services provided and to the extent permitted by state law.
- Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subject such person to criminal and civil penalties.

#### **Authorization To Deduct Contributions**

- I authorize deductions from my earnings or the required contributions, if any, toward the cost of the coverage. This authorization applies only if employee contributions are required.

#### **SPECIAL PROVISION FOR EMPLOYERS WITH SECTION 125 PLANS**

By allowing an individual to enroll in the Insurance Plan other than during the open enrollment period, CIGNA HealthCare or Connecticut General Life Insurance Company does not waive any terms of its contract. Further, by allowing an individual to enroll in the Insurance Plan other than during the open enrollment period, CIGNA HealthCare or Connecticut General Life Insurance Company does 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.