

Enrollment / Change Form



A	FOR EMPLOYER USE ONLY	Effective Date	Hire Date	Employer Name		Employer Address						
<input type="checkbox"/> New Hire <input type="checkbox"/> Open Enrollment		<input type="checkbox"/> Active <input type="checkbox"/> Retiree <input type="checkbox"/> COBRA		Account Number 3206140		Branch Code	Billing Group					
Type of Change: See Qualifying Events on Reverse												
<input type="checkbox"/> Address Change <input type="checkbox"/> Cancel Employee* <i>*Must also complete COBRA Notification Request Form</i>			<input type="checkbox"/> Add Dependent(s): List names in Section B <input type="checkbox"/> Cancel Dependent(s)* _____			<input type="checkbox"/> Retirement <input type="checkbox"/> Other: _____						
B	Employee Name (last) _____ (first) _____ (M.I.) _____					Social Security # _____						
Cell Phone _____			Home Phone _____		E-Mail Address _____							
Mailing Address (Street, Apt #, or PO Box) _____ (City) _____			(State) _____		(Zip Code) _____							
Last Name		First Name		M.I.	Plan	Social Security #		Date of Birth	Gender	Relationship to Subscriber <small>i.e. legally married, *domestic partner, biological, step or adopted child (*not all Employers offer DP coverage)</small>		
Employee				<input type="checkbox"/> Medical <input type="checkbox"/> Dental					<input type="checkbox"/> M <input type="checkbox"/> F	Spouse E-mail Address _____		
Spouse (whom you wish to cover)				<input type="checkbox"/> Medical <input type="checkbox"/> Dental					<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Legally Married <input type="checkbox"/> Domestic Partner*		
Dependent (whom you wish to cover)				<input type="checkbox"/> Medical <input type="checkbox"/> Dental					<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Biological <input type="checkbox"/> Step <input type="checkbox"/> Adopted		
Dependent (whom you wish to cover)				<input type="checkbox"/> Medical <input type="checkbox"/> Dental					<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Biological <input type="checkbox"/> Step <input type="checkbox"/> Adopted		
Dependent (whom you wish to cover)				<input type="checkbox"/> Medical <input type="checkbox"/> Dental					<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Biological <input type="checkbox"/> Step <input type="checkbox"/> Adopted		
C	Traditional Plan Suite Options		Consumer Driven Plan Suite Options		Dental _____ (insert plan code)			If declining coverage, please initial below. _____ Decline Medical Coverage _____ Decline Dental Coverage				
<input type="checkbox"/> Green Open Access <input type="checkbox"/> Red Open Access		<input type="checkbox"/> Yellow Open Access with Choice Fund <input type="checkbox"/> Yellow Open Access <input type="checkbox"/> Orange Open Access										
D	Other Health Care Coverage		Will you or your covered dependents have other health insurance while on SCHOOLCARE? <input type="checkbox"/> Yes <input type="checkbox"/> No									
Name of person covered		ID Number or Medicare No.			Effective Date		Name of Carrier		Medicare Part A	Medicare Part B	Medicaid	Other 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.

INSTRUCTIONS

EMPLOYER
Complete Section A - Employer and enrollment/change information Check box(es) indicating reason(s) for submitting enrollment/change request.
Complete Section E - in the lower right hand corner of the Form Employer must sign and date the Form after reviewing all information in order for it to be processed.
EMPLOYEE – Complete Sections B - E
Section B - Employee and Covered Dependent Information Complete all information in order for your enrollment/change request to be processed. <ul style="list-style-type: none">• Provide LEGAL NAME AND MIDDLE INITIAL for <u>all</u> enrollees.• Federal regulations require social security numbers for <u>all</u> enrollees.• Provide valid email address(es) to be sure you receive information regarding wellness cash incentives.
Section C - Plan Option Check one SCHOOLCARE medical plan option box that you are selecting as offered by your employer. Check one SCHOOLCARE dental plan option box, if applicable, and insert plan code. If declining coverage, initial accordingly.
Section D - Other Health Care Coverage Only complete for covered dependents on the plan who will maintain other insurance while on SCHOOLCARE.
Section E - Employee Verification Employee must sign and date the Form after completing and reviewing all information in order for it to be processed.

SPECIAL PROVISIONS FOR EMPLOYERS WITH SECTION 125 PLANS

By allowing an individual to enroll in the Insurance Plan other than during the open enrollment period, SCHOOLCARE, Cigna HealthCare or Cigna Health and Life Insurance Company do not waive any terms of its contracts. Further, by allowing an individual to enroll in the Insurance Plan other than during the open enrollment period, SCHOOLCARE, Cigna HealthCare or Cigna Health and Life Insurance Company 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.

QUALIFYING EVENTS

For a qualifying event, subscribers must provide notice within **30 days** of the event. Examples include:

- Marriage
- Loss of other insurance coverage
- Adoption/ Legal Guardianship
- Divorce/ Legal Separation (Subscriber or Spouse notification within 60 days)
- Birth of a child
- Death

CIGNA HEALTHCARE PROVISIONS

Applicant Acknowledgments and Agreements

On behalf of myself and the dependents listed on the reverse side, I agree to or with the following:

1. "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 Cigna Healthcare, Cigna Health and Life Insurance Company, Cigna Home Delivery Program and its affiliates, Cigna Behavioral Health, Inc., Intracorp, and HMO or service company subsidiaries of Cigna Health Corporation and Cigna Dental Health, Inc.
2. 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.
3. 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.
4. 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.