Primary Applicant Name_____
Enrollment Form ID _____

Cigna

Cigna Health and Life Insurance Company (Cigna)
Texas Individual and Family Plan Enrollment Application / Change Form

Our medical plans are only available in the following service areas/counties:

HOUSTON: Austin, Brazoria, Brazos, Chambers, Fort Bend, Galveston, Grimes, Harris, Liberty, Montgomery, San Jacinto, Walker, Waller, Washington

DALLAS: Collin, Cooke, Dallas, Denton, Ellis, Erath, Fannin, Grayson, Henderson, Hood, Hunt, Johnson, Kaufman, Navarro, Palo Pinto, Parker, Rockwall, Somervell, Tarrant, Wise

AUSTIN: Hays, Travis, Williamson

Section A. Type of Application

New Enrollment Application:
☐ Applicant Only ☐ Applicant and Dependent(s) ☐ Child(ren) Only

Existing Individual Plan Policy Member requesting a change in coverage:
☐ Add Family Member(s) or ☐ Request Plan Change

Subscriber Name:_____ Subscriber ID:_____

Requested Effective Date:*
☐ 1st of the Month of_____

Effective dates are assigned to the 1st of the month. Cigna will assign the next available effective date if not selected by the applicant.

** Requested Effective Date cannot be greater than 60 days after the Signature Date. No Effective Dates will be assigned prior to or on the Signature Date.*

Section B. Enrollment Criteria

Applications are accepted during annual open enrollment period or within 60 calendar days of a qualifying event. Please select the applicable enrollment reason.

☐ Annual Open Enrollment

☐ Special Enrollment Period *(Select the qualifying event below)*
- ☐ An individual and any dependents lost minimum essential health coverage
- ☐ An individual gained or became a dependent through marriage, birth, adoption, or placement for adoption
- ☐ An individual experienced an error in enrollment
- ☐ An individual adequately demonstrated that the plan or issuer substantially violated a material provision of the contract in which s/he is enrolled
- ☐ An individual became newly eligible or ineligible for advance payments of the premium tax credit or is experiencing a change in eligibility for cost-sharing reductions
- ☐ An individual or enrollee made a permanent move and new coverage is available

For any Special Enrollment Period reason, provide:

Name(s): _____ and Event Date(s): _____

Section C. Benefit Plan Options

Select Desired Benefit Plan:

Dallas/Fort Worth & Austin plans:

- ☐ myCigna Health Savings 6100
- ☐ myCigna Health Flex 5500
- ☐ myCigna Health Flex 5100
- ☐ myCigna Health Savings 3400
- ☐ myCigna Health Flex 1500
- ☐ myCigna Health Flex 2750
- ☐ myCigna Health Flex 5000
- ☐ myCigna Copay Assure Silver
- ☐ myCigna Health Flex 1900
- ☐ myCigna Health Flex 1250
- ☐ myCigna Copay Assure Gold

Houston plans:

- ☐ myCigna Health Flex 5100
- ☐ myCigna Health Flex 2750
- ☐ myCigna Health Flex 5000
- ☐ myCigna Copay Assure Silver
- ☐ myCigna Health Flex 1250
- ☐ myCigna Copay Assure Gold

Section D. Applicant and Family Members

Applicant's Last Name	First Name	M.I.	Social Security Number
Date of Birth / Age	☐ Single ☐ Married / ☐ Male ☐ Female		Primary Care Physician ID Number optional _____ Current Patient: ☐ Yes ☐ No
Mailing Address – Home Address Required _____ Street _____ City State _____ ZIP Code (Please provide 9-digit ZIP Code)	Billing Address – If different than mailing address _____ Street _____ City State _____ ZIP Code	County Email Address:	Home Phone Number: ( ) _____-_____ Cell Phone Number: ( ) _____-_____ Work Phone Number: ( ) -

Applicant's Spouse Last Name		First Name		M.I.	Social Security Number
Date of Birth	Age	☐ Single ☐ Married	☐ Male ☐ Female		Primary Care Physician ID Number optional _____ Current Patient: ☐ Yes ☐ No

Does this person live at the same address as the Applicant? ☐ Yes ☐ No
If no, list address (Street, City, State, 9-digit ZIP Code and County):
_____

Dependent children are covered up to age 26.
☐ Check here if you are providing names of additional dependents on an attached separate page.

Applicant's Dependent Last Name		First Name		M.I.	Social Security Number
Date of Birth	Age	☐ Single ☐ Married	☐ Male ☐ Female		Primary Care Physician ID Number optional _____ Current Patient: ☐ Yes ☐ No

Does this person live at the same address as the Applicant? ☐ Yes ☐ No
If no, list address (Street, City, State, 9-digit ZIP Code and County):
_____

Applicant's Dependent Last Name		First Name		M.I.	Social Security Number
Date of Birth	Age	☐ Single ☐ Married	☐ Male ☐ Female		Primary Care Physician ID Number optional _____ Current Patient: ☐ Yes ☐ No

Does this person live at the same address as the Applicant? ☐ Yes ☐ No
If no, list address (Street, City, State, 9-digit ZIP Code and County):
_____

D1. Are all enrollees residents of the United States? ☐ Yes ☐ No
If you answered "No" to the above question, provide names of non residents:
_____

D2. Do all enrollees reside within the State of Texas and within the service area of the selected benefit plan? ☐ Yes ☐ No
If you answered "No" to the above question, provide names of non residents:
_____

Cigna Use Only:	Effective Date:

Section E. Prior / Current Coverage Information

E1. Has any person applying for coverage been covered within the last 63 days from the signature date? ☐ Yes ☐ No
Persons Covered: _____ Effective date: _____ Termination date: _____
Prior or Current Health Plan Carrier: _____
Is your current coverage still in effect? ☐ Yes ☐ No

E2. Each applicant must agree to cancel all other health policies or plans, including HMO or PPO coverage, providing benefits for health services similar to this plan.

Section F. Health Related Questions

F1. Has any applicant smoked or used tobacco products on average for four (4) or more times per week within the past six months (includes chewing tobacco, cigarettes, cigars and pipes, excludes religious or ceremonial use of tobacco)? ☐ Yes ☐ No
If yes, list applicant name(s) and the last time they smoked or used tobacco products:
Name(s): _____

Section G. Important Information

1. ☐ I prefer to receive written correspondence regarding this application via email.

2. Please do not cancel other current health insurance coverage until written notification is received from Cigna indicating that your application has been approved, and you and your dependents are in receipt of your ID cards.

Section H. Payment Method

NOTE: Electronic Funds Transfer - EFT (Automatic draft from a checking or savings account) and Credit Card are the only initial payment methods allowed for online or faxed applications. The accounts will be charged only upon approval of your Application.

Electronic Funds Transfer – EFT (Automatic draft from a checking or savings account)

☐ Yes, I am requesting EFT both for my initial payment and for ongoing monthly payments (no paper or electronic monthly billing statement will be issued).

Account Number:_____ ☐ Checking ☐ Saving

Routing Number: ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

Name of Bank:_____ Name(s) on Account:_____

I authorize the Company (Cigna and Connecticut General Life Insurance Company) to make monthly withdrawals, in the amount of my monthly premium, from my bank account as identified on this form and authorize the banking facility (Bank) to charge such withdrawals to my account. This authority will remain in effect until the Company receives written notice from me that the authority is terminated. Such termination will be effective with respect to the next premium due following 21 days after the written notice is received by the Company. I understand that if for any reason, a withdrawal is not honored by the Bank (including, but not limited to, insufficient funds or my direction to the Bank not to honor the withdrawal) my health care contract premium will be unpaid, and failure to pay my health care contract premium may result in termination for my health care contract, that I may be charged an administration fee in addition to my healthcare premium, and that this authorization will remain in place until cancelled and that any due or past due premiums may be withdrawn under this authorization. I understand and agree that termination of this authorization does not relieve me of responsibility for charges incurred under my health care contract. I agree to indemnify and hold harmless the Company and its affiliates and employees for any claims arising out of transfers or deductions from my account in accordance with this authorization.

Any premium adjustment will automatically be charged to your account. Please be advised that the premium adjustment may reflect an increase.

Credit Card (Available for initial payment only)	☐ VISA ☐ MASTERCARD
Cardholder's Name – exactly as it appears on the card:	
Account Number: ☐☐☐☐-☐☐☐☐ - ☐☐☐☐-☐☐☐☐ Account Holder's ZIP Code: ____ ____ ____ ____ ____ – ____ ____ ____ ____	Card Expiration Date:

Any premium adjustment will automatically be charged to your account.
Please be advised that the premium adjustment may reflect an increase.

For Paper Application: ***Please check here:*** ☐ Paper check is attached or ☐ Credit card information provided.

Ongoing Payment Options if paying by paper check or credit card for initial payment (please select one option only)

☐ **Monthly Paper Bill:** Yes, I am submitting a paper check (or have selected the credit card option) for my initial payment. I will submit a check for my ongoing monthly payments.

☐ **EFT Draft:** Yes, I am submitting a paper check for my initial payment (or have selected the credit card option) and I am requesting recurring automatic EFT drafts for ongoing monthly payments. (No paper or electronic monthly or quarterly billing statements will be issued.) *Please complete the EFT section above.*

☐ **Monthly Electronic Bill (eBill):** Yes, I am submitting a paper check (or have selected the credit card option) for my initial payment and agree that I am responsible for initiating all subsequent electronic monthly payments. I am requesting monthly electronic bills (eBills) to be sent to my email account provided in Section D of this application.

For Online electronic submitted Application:
Ongoing Payment Options if Credit Card Option was selected for initial payment (please select one option only).

☐ **EFT Draft:** Yes, I agree to recurring automatic EFT drafts for my ongoing monthly payments. (No paper or electronic monthly billing statement will be issued.) Please complete the EFT section above.

☐ **Monthly Electronic Bill (eBill):** Yes, I agree that I am responsible for initiating my ongoing electronic monthly payments. I am requesting monthly electronic bills (eBills) to be sent to my email account as provided in Section D of this application.

Section I. Statement of Accountability – *To be completed when applicant can not complete the application.*

I, _____, personally read and completed this Enrollment Application Form for the Applicant named below because:

☐ Applicant does not read English ☐ Applicant does not speak English ☐ Applicant does not write English

☐ Other (explain):_____

I personally translated the contents of this application disclosed by:

_____

I also personally translated and fully explained the Conditions and Agreement Section:

_____ _____

Signature of Translator *required* *(Excludes Parent Signature if Child Only Application)* | Today's Date *required*

Section J. Producer Section

Writing Producer Name:		Producer Code:
Street Address:	City:	State: ZIP Code:
Email Address:		
Phone Number:		
Are you aware of any information about your client not disclosed on this application?		☐ Yes ☐ No
Did you see the proposed applicant at the time this application was completed? If "No", please explain:_____		☐ Yes ☐ No

I verify that the application was completed by the applicant unless otherwise noted in the Statement of Accountability. I verify that the applicant has received the required Outline of Coverage.

Signature of Writing Producer:		Date:
Please enter the name of the Agency/Producer that checks are to be made payable to if different from Writing Producer.		Producer Code:
Street Address:	City:	State: ZIP Code:
Email Address:		
Phone Number:		
Cigna Sales Representative Last Name:		First Name:

Section K. Conditions and Agreement/Authorization

1. I understand that during the application process and after my enrollment, Cigna and other direct or indirect subsidiaries of Cigna Corporation (collectively "Cigna") may obtain and provide Confidential Information to others. For purposes of this Paragraph and Paragraph 2 and 3 below, "Confidential Information" means Payment Records, or Privileged Information; dental; disability; accident; or workers' compensation related information.
2. I authorize any insurance institution, employer, provider, insurance support organization, health care organization, and their agents and representatives to provide Confidential information on request by Cigna to representatives of Cigna who are authorized by Cigna to receive such information, to any Cigna participating provider, or to any other provider, person or entity performing a service for the following purposes: Plan administration, validating services and benefits payable under the Plan, performance of peer review, utilization management, quality assurance, grievance and appeals, care management, and/or to access the quality of or access to health care services and supplies. I further authorize Cigna (through its agents and representatives who are authorized by Cigna to disclose confidential information) to provide Confidential Information to the person or entities above when it determines that such disclosure is necessary or appropriate for the purpose specified in this paragraph or as otherwise authorized by applicable state or federal law, including the Health Insurance Portability and Accountability Act (HIPAA) Privacy Standards (45 C.F.R. Parts 160 and 164, Subpart E).

   I authorize Cigna to use such information and to disclose such information to affiliates, Providers, payors, other insurers, third party administrators, vendors, consultants, governmental authorities with jurisdiction when necessary for my care or treatment, payment for services, the operation of my health plan, or to conduct related activities.
3. I am providing authorization for myself and as agent or representation of my spouse and any dependent children. I understand that this authorization will remain in effect until I send written notice revoking it to Cigna or for such shorter period as required by law. I understand that to the extent this authorization applies to information collected in connection with this application for coverage, the authorization is valid for a period of thirty (30) months. I further understand that to the extent this authorization applies to information collected in connection with a claim for benefits under the Plan, the authorization is valid for and with respect to services received during the term of coverage under the Plan. Until revoked by me or by operation of law, this authorization remains in effect and may be relied on by Cigna and other parties.
4. I understand that any person who knowingly and with intent to defraud any insurance company or 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 fraudulent insurance act and may be subject to civil and criminal penalties.
5. I authorize that payment be made under Part B of Medicare to Cigna for medical and other services furnished by Cigna for which it pays or has paid, if applicable.
6. I agree that in the event health services provided or covered are the primary responsibility of Medicare, workers' compensation coverage, automobile medical payment coverage, or other payments source Cigna may be authorized by applicable law to pursue, to fully inform Cigna 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.
7. I understand that I or my authorized representative is entitled to receive a copy of this authorization form.
8. I understand that information disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and will no longer be protected by federal privacy regulations.
9. I acknowledge that I have received an outline of coverage.

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: 1) 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; and 2) use of an assigned identification number does not eliminate the possibility that another individual will access or misuse information related to that number.

I AGREE ON BEHALF OF MYSELF AND AS AUTHORIZED AGENT OR REPRESENTATIVE OF MY ELIGIBLE DEPENDENTS TO THE PROVISIONS CONTAINED ON THIS FORM.

All applicants 18 years and older must sign and date application, acknowledging their understanding of and agreement to the conditions listed above.

The above statements are true and complete to the best of my knowledge and belief. I understand and agree that for my child, and/or me and my eligible dependents, these statements shall be the basis for determination of acceptance for coverage under my applicable Cigna benefit plan. I acknowledge and agree that any misrepresentation or intentional omission of any applicant will render this contract null and void from its date of issue in accordance with applicable law. If my coverage is revoked I will receive written notice that will explain the decision and my right to appeal. I also understand that I will be required to pay for any services that were covered while a member and that Cigna will refund all amounts paid by me except amounts owed to Cigna.

Applicant Signature	Today's Date (MM/DD/YYYY)	Applicant Spouse's Signature	Today's Date (MM/DD/YYYY)
Applicant's Dependent Age 18 or Older	Today's Date (MM/DD/YYYY)	Applicant's Dependent Age 18 or Older	Today's Date (MM/DD/YYYY)

Section L. Instructions

- The applicant is responsible for ensuring that the application is complete and truthful.
- Print clearly using black or blue ink.
- The application must be received by Cigna within 30 days from the signature date.
- Coverage will become effective only if this application enrollment form is accepted and appropriate premium is enclosed.
- Do not cancel your current coverage until you have received notification from Cigna.
- Effective dates are generally assigned to the 1st of the month. The next available effective date will be assigned, if not selected by the applicant.

Section M. Contact Information

Please return the application enrollment form to the broker or submit to the address listed below:

Cigna Individual and Family Plans
P.O. Box 30362
Tampa, FL 33630-3362

FAX # 1.877.484.5927

www.cigna.com

If you have questions about completing this application, please call Cigna at 1.866.GET.Cigna (1.866.438.2446) 8:00 AM – 8:00 PM ET