

# CIGNA Dental and Vision Enrollment Form

CIGNA Dental Health, Inc.  
 Insured dental and vision plans underwritten by  
 Connecticut General Life Insurance Company  
 P.O. Box 692012  
 San Antonio, TX 78269



TOTAL P.02

Employer: Complete Section A  
 Employee: Complete Sections B, C & D

Please print and thank you for providing this information

**A**

<input type="checkbox"/> OPEN ENROLL	<input type="checkbox"/> CHANGE	EFFECTIVE DATE OF ADD/CHANGE/ CANCELLATION (MM/DD/CCYY)	EMPLOYER NAME	EMPLOYER ADDRESS		
<input type="checkbox"/> NEW ENROLL	<input type="checkbox"/> REINSTATE					
CIGNA ACCOUNT NO.	DIVISION/BRANCH/LOCATION/CLASS	DATE OF HIRE (MM/DD/CCYY)	NETWORK ID	BRANCH CODE	CDH GROUP NO.	DENTAL BENEFIT OPTION
TYPE OF CHANGE: <input type="checkbox"/> Add Dependent(s) * Date: _____ <input type="checkbox"/> Cancel Employee Last Date of Coverage: _____ <input type="checkbox"/> Cancel Dependent(s) * Last Date of Coverage: _____ Reason for Cancellation: <input type="checkbox"/> Leave employment <input type="checkbox"/> Transfer out of CIGNA Dental Care area <input type="checkbox"/> Transfer to another plan <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"/> Other _____						

\* List Names in Section C

**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	
ADDRESS (Street)		(City)		(State)	(Zip Code)	
WHAT IS YOUR PRIMARY LANGUAGE? (optional)	DO YOU HAVE A DISABILITY AFFECTING YOUR ABILITY TO COMMUNICATE OR READ? (optional)		SELECT PLAN:			
	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> CIGNA Dental Care <input type="checkbox"/> CIGNA Dental EPO <input type="checkbox"/> CIGNA Vision <input type="checkbox"/> CIGNA Dental PPO <input type="checkbox"/> CIGNA Traditional			

**C**

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	GENDER	FULL-TIME STUDENT? Yes No	DENTAL OFFICE SELECTION (for CIGNA Dental Care only)	START DATE OF CONTINUOUS DENTAL COVERAGE (for CIGNA Dental PPO only) (Month, Day, Year)	(check one)
Last Name	First Name	M.I.							
Employee					<input type="checkbox"/> M <input type="checkbox"/> F		1st Choice - 2nd Choice -		<input type="checkbox"/> Add <input type="checkbox"/> Cancel
Spouse					<input type="checkbox"/> M <input type="checkbox"/> F		1st Choice - 2nd Choice -		<input type="checkbox"/> Add <input type="checkbox"/> Cancel
Dependent	Relationship				<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> <input type="checkbox"/>	1st Choice - 2nd Choice -		<input type="checkbox"/> Add <input type="checkbox"/> Cancel
Dependent	Relationship				<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> <input type="checkbox"/>	1st Choice - 2nd Choice -		<input type="checkbox"/> Add <input type="checkbox"/> Cancel
Dependent	Relationship				<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> <input type="checkbox"/>	1st Choice - 2nd Choice -		<input type="checkbox"/> Add <input type="checkbox"/> Cancel

Please submit proof of student or handicapped status for coverage dependents.  
 The original effective date must be completed for each member in order for continuous coverage credit to be applied toward waiting period.

**D**

**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

CIGNA Dental refers to the following operating subsidiaries of CIGNA Corporation: Connecticut General Life Insurance Company and CIGNA Dental Health, Inc., and its operating subsidiaries and affiliates. The CIGNA Dental Care plan is provided by CIGNA Dental Health Plan of Arizona, Inc., CIGNA Dental Health of California, Inc., CIGNA Dental Care of Colorado, Inc., CIGNA HealthCare of Connecticut, Inc., CIGNA Dental Health of Delaware, Inc., CIGNA Dental Health of Florida, Inc., a Prepaid Limited Health Services Organization licensed under Chapter 636, Florida Statutes, CIGNA Dental Health of Kansas, Inc. (Kansas and Nebraska), CIGNA Dental Health of Kentucky, Inc., CIGNA Dental Health of Illinois, Inc., CIGNA Dental Health of Maryland, Inc., CIGNA Dental Health of Missouri, Inc., CIGNA Dental Health of New Jersey, Inc., CIGNA Dental Health of North Carolina, Inc., CIGNA Dental Health of Ohio, Inc., CIGNA Dental Health of Pennsylvania, Inc., CIGNA Dental Health of Texas, Inc., and CIGNA Dental Health of Virginia, Inc. In other states, the CIGNA Dental Care plan is underwritten by Connecticut General Life Insurance Company and administered by CIGNA Dental Health, Inc. The CIGNA Dental PPO and CIGNA Dental EPO plans are underwritten or administered by Connecticut General Life Insurance Company with network management services provided by CIGNA Dental Health, Inc., and certain of its operating subsidiaries. The CIGNA Traditional and CIGNA Vision plans are underwritten or administered by Connecticut General Life Insurance Company.

NOTE: Not all products are available for all clients or all states. Check your enrollment materials carefully to see what is offered for your group.

DEC-14-2010 14:26