Cigna Dental Enrollment Form

Retirees Association: Complete Section A
Retiree: Complete Sections B, C & D

Insured and/or Administered by
Cigna Health and Life Insurance Company

Cigna.

Please print and thank you for providing this information

A

☐ OPEN ENROLL ☐ CHANGE ☐ NEW ENROLL ☐ REINSTATE

EFFECTIVE DATE OF ADD/CHANGE/ CANCELLATION (MM/DD/CCYY)

EMPLOYER NAME: LOCAL IDD RETIREES ASSOCIATION

EMPLOYER ADDRESS: 195 MONTAGUE ST, 3RD FL, BROOKLYN, NY 11201

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:

☐ Add Dependent(s) Date: _____

* ☐ Cancel RETIREE Last Date of Coverage: _____

☐ Cancel Dependent(s) * Last Date of Coverage: _____
Reason for Cancellation:
☐ Leave employment
☐ Transfer out of Cigna Dental Care area
☐ Transfer to another plan

* List Names in Section C

☐ Address Change

☐ Transfer to COBRA
☐ 18 mos. ☐ 29 mos. ☐ 36 mos.

☐ Other _____

B

RETIREE NAME (Last) (First) (M.I.)

SOCIAL SECURITY NO

RETIREE DATE OF BIRTH (MM/DD/CCYY)	HOME PHONE	CELL PHONE	HOME E-MAIL ADDRESS	RETIREE 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) ☐ Yes ☐ No

SELECT PLAN: Choose one
☐ DHMO (Dental Care) ☐ Cigna Dental EPO
☐ Cigna Dental PPO ☐ Cigna Traditional

C

I WOULD LIKE COVERAGE FOR ME AND MY DEPENDENTS. (Specify last name if different from yours) Last Name / First Name / M.I.	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)
RETIREE			☐ M ☐ F		1st Choice - 2nd Choice -		☐ Add ☐ Cancel
Spouse			☐ M ☐ F		1st Choice - 2nd Choice -		☐ Add ☐ Cancel
Dependent Relationship			☐ M ☐ F	☐ ☐	1st Choice - 2nd Choice -		☐ Add ☐ Cancel
Dependent Relationship			☐ M ☐ F	☐ ☐	1st Choice - 2nd Choice -		☐ Add ☐ Cancel
Dependent Relationship			☐ M ☐ F	☐ ☐	1st Choice - 2nd Choice -		☐ Add ☐ Cancel

Proof of student or handicapped status for overage dependents may be required
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.

RETIREE'S SIGNATURE / DATE

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.

DISTRIBUTION: White - Cigna **Canary** - Member **Pink** - Employer