Wells Fargo Insurance Services

CIGNA Vision Enrollment Form

Independent Business Owners Program

Office Use Only Website

Independent Business Owners, Spouses And Families

Please mail your completed enrollment form to Wells Fargo Insurance Services, P. O. Box 338, Grand Rapids, MI 49501-0338.

Coverage becomes effective on the first day of the month following our receipt of your completed enrollment form and premium.

IBO # | IBO Level

Please Check One:

☐ New Enrollment ☐ Change, provide reason.

Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim or an application containing any false or misleading information is guilty of insurance fraud and subject to civil and criminal penalties. (In Florida, this is a felony of the third degree.)

General information. Please print.

Applicant's Name

Address | Apt. Number | City | State | ZIP

Daytime Phone | Home Phone | Fax Number

E-mail Address | May we send you Wells Fargo Insurance Services updates by e-mail? ☐ Yes ☐ No

Handicapped dependents over the age of 26 - Please attach a Physician's Statement

Complete for all persons to be covered

Relationship	Name (Including Last if Different)	Date of Birth	Gender	Social Security Number	Address (If Different)	Circle One
Self			M/F			Add / Cancel
Spouse			M/F			Add / Cancel
Child			M/F			Add / Cancel
Child			M/F			Add / Cancel
Child			M/F			Add / Cancel
Child			M/F			Add / Cancel
Child			M/F			Add / Cancel
Child			M/F			Add / Cancel

I accept the coverage / insurance benefits provided by this group plan and authorize the processing of my enrollment in the coverage as indicated on this form. I accept responsibility of paying the entire cost of the coverage.

I authorize any participating provider office to release records and billing information concerning me or my dependents to Connecticut General Life Insurance Company or its designee for purposes of plan administration or for the purpose of validating and determining benefits payable. I further authorize Connecticut General Life Insurance Company or its designee to release any records or information concerning me or my dependents, for purposes of plan administration and customer service.

California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance coverage. Connecticut General Life Insurance Company and its designee do not require such tests in any state as a condition of obtaining coverage.

Billing Mode (check one) ___monthly ___quarterly ___semi-annual ___annual

Enclosed is my monthly premium (payable to Wells Fargo Insurance Services) of

$

I understand that I may continue to receive my premium statements monthly.

I have read and accepted the provisions printed above.

Signature of Applicant | Date

"CIGNA" refers to the various operating subsidiaries of CIGNA Corporation. Products and services are provided by these subsidiaries and not by CIGNA Corporation. Benefits are underwritten or administered by Connecticut General Life Insurance Company. This information is intended as a summary of benefits only. It does not describe all the terms, provisions and limitations of your plan. Participating providers are independent contractors solely responsible for your routine vision examinations and products. In Arizona and Louisiana, the CIGNA Vision product is referred to as CG Vision.