Dental Insurance Enrollment/Change Form

CIGNA
A Business of Caring.

***INSTRUCTIONS:* Top box to be completed by the Employer/Plan Sponsor.**
Remainder to be completed by the Employee.

Name of Employer/Plan Sponsor:	**Group/Plan:**	**Agency/Department Name:**	**Agency/Department Number:**
North Dakota Public Employees Retirement	**3328472**		

This change is due to:			**Effective Date of Coverage or Change:**
☐Initial Eligibility Following Hire	☐Address Change	☐Cancel Coverage	
☐Annual Enrollment	☐Add Dependent	☐Loss of Other Coverage	
☐Late Entrant due to Change in Family Status*	☐Remove Dependent	☐Termination	
☐Change Agency from _____ to _____		☐Retirement	

* A late entrant is an individual who is first enrolling for dental coverage after the first available opportunity.

Employee Name *(last, first, middle initial)*	☐Female ☐Male	Date of Birth	Social Security #
Employee Address *(street address, city, state, zip code)*	☐Single ☐Married ☐Divorced ☐Widowed ☐Legally Separated		Telephone Work Home

Elect or Decline Coverage

Elect Dental Coverage	☐ **Employee Only** ☐ **Employee + Spouse** ☐ **Employee + Child(ren)** ☐ **Employee + Family**
Waive Dental Coverage	**IF YOU DO NOT WANT COVERAGE, COMPLETE THIS SECTION.** I have been given an opportunity to apply for Group Dental Insurance and have decided waive coverage for: (check all that apply) ☐myself ☐ spouse only ☐child(ren) only ☐myself and entire family

Dependent Information *Complete for covered spouse and each covered child. Attach separate sheet if more room is needed.*

Dependent Name *(last, first, middle initial)*	Relationship to Employee	Gender (F or M)	Date of Birth	Marital Status*	Child Status**	Add or Delete

* For Marital Status, enter one of the following: Single, Married, Divorced, Widowed, Legally Separated.
** For Child Status, indicate "S" if full-time student or "H" if handicapped, or leave blank if neither.

Other Dental Coverage Information *Complete if you and/if any dependent have dental coverage with another insurer or carrier.*

Employee/Dependent Name *(last, first, middle initial)*	Name and Address of Other Dental Insurer/Carrier	Policy/Plan Number	Effective Date	Other Dental Coverage Type
				☐ Single ☐ Family
				☐ Single ☐ Family

READ THIS INFORMATION CAREFULLY AND THEN SIGN AND DATE BELOW↓

- I authorize my employer to deduct from my wages the premium, if any, for the elected coverage.
- To the best of my knowledge and belief, the information I have provided on this form is correct.
- **I understand that any person who knowingly and with intent to defraud, submits an application or files a claim containing any materially false or misleading information, commits a fraudulent act, which is a crime.**
- I understand my coverage begins on the effective date assigned by the dental carrier, provided I am actively at work.

Employee's Signature	Date Signed

Enter your name, gender, date of birth, social security number, mailing address, marital status, and telephone numbers.

Elect Coverage

Select the level of coverage. If electing Employee + Spouse, Employee + Child(ren), or Employee + Family, complete spouse and dependent coverage information. If you are adding or dropping a spouse or dependent, ensure that you check the appropriate box.

Waive Coverage

Select who is waiving coverage.

Other Dental Coverage

Indicate if you and/or any dependent have other dental coverage.

You must sign and date this form for it to be valid.