Employer: Complete Section A
Employee: Complete Section B-N

Enrollment/Change Form Comprehensive

Insured and/or Administered by
Connecticut General Life Insurance Company

CIGNA

A

☐OPEN ENROLL ☐ CHANGE ☐ NEW ENROLL ☐ REINSTATE	EFFECTIVE DATE OF ADD/CHANGE/CANCELLATION (MM/DD/CCYY) _____/_____/_____	EMPLOYER NAME	DATE OF HIRE (MM/DD/CCYY) _____/_____/_____	PLAN NUMBER	SUBGROUP	CLASS

B

☐ SINGLE ☐ MARRIED _____/_____/_____ ☐ SEPARATED ☐ DIVORCED ☐ WIDOWED	TYPE OF CHANGE ☐ Add Dependent(s) * ☐ Demographics ☐ PCP Change ☐ Retirement * List Name(s) in Section C ☐ COBRA Continuation ☐ Other _____ Qualifying Event Date: _____/_____/_____

C

EMPLOYEE NAME *(Last)*	*(First)*	*(M.I.)*	SOCIAL SECURITY NUMBER
EMPLOYEE DATE OF BIRTH (MM/DD/CCYY) _____/_____/_____	HOME PHONE ( )	WORK PHONE ( )	HOME E-MAIL ADDRESS / EMPLOYEE IDENTIFICATION NO.
ADDRESS *(Street)*	*(City)*	*(State)*	*(Zip Code)*

☐ YES I WOULD LIKE COVERAGE FOR MYSELF AND MY DEPENDENTS. (Specify last name if different from yours) Last Name First Name M.I.	DEPENDENT SOCIAL SECURITY NUMBER	DATE OF BIRTH (MM/DD/CCYY)	GENDER	HEIGHT	WEIGHT	FULL TIME STUDENT?	Note: PCP selection is optional
Employee		____/____/____	☐M ☐F				PCP -
Dependent Relation		____/____/____	☐M ☐F			☐ YES ☐ NO	PCP -
Dependent Relation		____/____/____	☐M ☐F			☐ YES ☐ NO	PCP -
Dependent Relation		____/____/____	☐M ☐F			☐ YES ☐ NO	PCP -
Dependent Relation		____/____/____	☐M ☐F			☐ YES ☐ NO	PCP -

ADDITIONAL INFORMATION: * DEPENDENTS – If full time student and age 19 or over, attach proof verifying credit hours. If totally disabled prior to age 19, attach proof of disability for eligibility review.

D

MEDICAL OPTIONS:	EE	EE+SP	EE+CH	EE+FAM
☐ Consumer Advantage/_____	☐	☐	☐	☐
☐ PPO/_____	☐	☐	☐	☐
☐ HSA/_____	☐	☐	☐	☐
☐ HRA/_____	☐	☐	☐	☐
☐ HO/_____	☐	☐	☐	☐
☐ Open Access Plus/_____	☐	☐	☐	☐
☐ Indemnity/_____	☐	☐	☐	☐
☐ Decline Coverage				

E

DENTAL OPTIONS:	EE	EE+SP	EE+CH	EE+FAM
☐ Indemnity/ _____	☐	☐	☐	☐
☐ Indemnity/ _____	☐	☐	☐	☐
☐ Decline Coverage				

F

LIFE AND AD&D OPTIONS:	Beneficiary Name	Relationship	%
☐ Life			
☐ Dependent Life – Spouse			
☐ Dependent Life – Child			
☐ Accidental Death & Dismemberment (AD&D)			
☐ Decline Coverage			

G

OTHER HEALTHCARE COVERAGE: Do you or your dependents have other health insurance under a group plan, HMO, or Medicare? ☐ Yes ☐ No If yes, please provide the following:

NAME OF PERSON COVERED	SOCIAL SECURITY NO	EFFECTIVE DATE	MEDICARE Part A	MEDICARE Part B	MEDICAID	OTHER INSURANCE CARRIER
		_____/_____/_____	☐	☐	☐	
		_____/_____/_____	☐	☐	☐	

H

OTHER CARRIER			EE	EE+SP	EE+CH	EE+FAM						
OPTIONS:	☐		☐	☐	☐	☐	☐		☐	☐	☐	☐
	☐		☐	☐	☐	☐	☐		☐	☐	☐	☐
	☐		☐	☐	☐	☐	☐		☐	☐	☐	☐
	☐		☐	☐	☐	☐	☐		☐	☐	☐	☐

I	
	PAYROLL SIGNATURE **By my signature below, I acknowledge that I have read and understand the disclosure in this application. I authorize the required payroll deduction for contributory benefits. I also represent that all information shown on this application is correct.**
	EMPLOYEE'S SIGNATURE / DATE

J

Tobacco Use	FULL NAME	GENDER	DOB	HEIGHT	WEIGHT	TOBACCO (use during past 5 yrs)	
Employee/Self		☐M ☐F	/ /	_____ FT _____ In	_____ Lbs	☐ YES- when was last use ?	☐NO
Spouse/Domestic Partner		☐M ☐F	/ /	_____ FT _____ In	_____ Lbs	☐ YES- when was last use ?	☐NO
Child/Dependent		☐M ☐F	/ /	_____ FT _____ In	_____ Lbs	☐ YES- when was last use ?	☐NO
Child/Dependent		☐M ☐F	/ /	_____ FT _____ In	_____ Lbs	☐ YES- when was last use ?	☐NO

K

HEALTH HISTORY: Please check YES or NO to each category. For any YES response, provide the details in the section below for any condition(s) that were diagnosed, consulted on or treated during the past 5 years.

During the past **5 years**, have you or your dependent(s) been diagnosed with, consulted on, treated or hospitalized for any adverse health conditions (see list of potential conditions below)? ☐ YES ☐ NO **If YES, please complete the detail below.**

☐ YES	☐ NO	1.	**Heart/Circulatory** (including but not limited to Angioplasty/Stent, Aneurysm, Blood Clots, Blood Disorder, Bypass, Cardiac Arrhythmia, Congestive Heart Failure, Coronary Heart Disease, Heart Murmur, Hemophilia, High Blood Pressure, Peripheral Artery Disease, Pacemaker/Defibrillator, Sickle Cell Anemia, Stroke/TIA or Ventricular Tachycardia). If **YES** to Stroke/TIA, please include additional information in the "Comments" section below including residuals (complications) and the degree of recovery.
☐ YES	☐ NO	2.	**Eyes/Ears/Nose/Throat** (including but not limited to Acoustic Neuroma, Cleft Lip/Palate, Deviated Septum or Retinopathy)
☐ YES	☐ NO	3.	**Immune** (including but not limited to AIDS/HIV+, CIDP, Immuno Deficiency, Lupus, Psoriasis or Scleroderma)
☐ YES	☐ NO	4.	**Cancer/Tumors** If **YES,** please include additional information in the "Comments" section below including type, stage or level of advancement, if and where it has spread beyond the original site, radiation/chemotherapy, and any surgeries completed, pending or expected.
☐ YES	☐ NO	5.	**Neurological** (including but not limited to ASL, Myasthenia Gravis, Cerebral Palsy, Multiple Sclerosis, Paralysis/Hemiplegia/Quadriplegia or Seizures/Convulsions/Epilepsy)
☐ YES	☐ NO	6.	**Transplants** If **YES**, please include additional information in the "Comments" section below including transplants completed, pending, expected or discussed, type of transplant (BMT, stem cell, specific organ) and any complications or signs of rejection.
☐ YES	☐ NO	7.	**Arthritis** (including but not limited to Osteoarthritis or Rheumatoid Arthritis)
☐ YES	☐ NO	8.	**Bones/Muscles/Joints** (including but not limited to Bulging/Herniated Disk, Fibromyalgia, Joint Replacement, Knee Problem or Disorder, Muscular Dystrophy, Neck/Back Pain or Disorder, Regional Pain Syndrome/Chronic Pain or Spina Bifida) If **YES** to Joint Replacement, please include additional information in the "Comments" section below including date of replacement.
☐ YES	☐ NO	9.	**Liver/Kidney/Urinary** (including but not limited to Bladder Disorder, Prostate Disorder, Liver Disease/Disorder, Hepatitis, Cirrhosis, Kidney Disease/Disorder, Renal Failure or Dialysis) If **YES** to Hepatitis, please include additional information in the "Comments" section below including the type of Hepatitis. If **YES** to Renal Failure, please include additional information in the "Comments" section below including whether it is end stage or chronic. If **YES** to Dialysis, please include additional information in the "Comments" section below including type (hemo or peritoneal), Medicare eligible date and expected Medicare primary date.
☐ YES	☐ NO	10.	**Endocrine/Metabolism** (including but not limited to Diabetes, Neuropathy/Other Complications, Fabry's Disease, Gaucher's Disease, Growth Hormone Deficiency/Dwarfism or Hurler's Disease). If **YES** to Diabetes, please include additional information in the "Comments" section below including whether it is controlled by diet, oral medication or insulin.
☐ YES	☐ NO	11.	**Reproductive** (including but not limited to Endometriosis, Fibroids or Ovarian Cysts)
☐ YES	☐ NO	12.	**Lung/Respiratory** (including but not limited to Asthma, COPD/Emphysema, Cystic Fibrosis, Lung Disorder, Sarcoidosis, Sleep Apnea or Tuberculosis). If **YES** to COPD/Emphysema, please include additional information in the "Comments" section below including if you are on oxygen.
☐ YES	☐ NO	13.	**Intestinal** (including but not limited to Crohn's Disease, Diverticulitis/Diverticulum, Gallbladder Disorder, Gastric Bypass, Pancreatitis or Ulcerative Colitis)
☐ YES	☐ NO	14.	**Psychological** (including but not limited to Alcoholism, Bipolar, Depression, Substance Abuse, Eating Disorder or Schizophrenia)
☐ YES	☐ NO	15	**Current Pregnancy** If **YES**, please include additional information in the "Comments" section below including due date, if multiple births are expected, the number of babies, complications or whether a C-Section is expected.
☐ YES	☐ NO	16.	**Any Other Condition Not Listed Above** If **YES**, please include additional information below.

L

HEALTH HISTORY DETAILS ****If more space is needed for your responses, please attach the additional information on a separate page and sign and date the page.****

Name of Member with Condition	Condition/Specific Diagnosis	Diagnosis/Treatment (Including surgeries completed or expected and complications)	Diagnosis Date	Treatment Status and Date Last Treated	Comments
			____/____/____		
			____/____/____		
			____/____/____		

M

FAMILY MEDICATIONS: Including all oral, topical, optical, nasal, injected or IV infused therapies

Are you or your dependent(s) taking any prescription medication (including any oral, topical, optical, nasal, injected or IV infused therapies)? ☐ YES ☐ NO **If YES, please provide below, information on all medication currently being taken.**

Name of Member	Medicine Being Taken	Dosage & Frequency of Use	Date Prescribed	Date Last Taken or Ongoing	Condition(s) Being Taken For

N

I understand that I will not be individually denied coverage or be individually charged different rates as a result of my answers. However, if I knowingly provide false information on this Questionnaire, I understand and agree that it may affect the payment of claims or result in termination of my/or my dependent(s) coverage.

EMPLOYEE'S SIGNATURE:	Social Security Number	Date: (MM/DD/YYYY)	Phone Number:

DISCLOSURE INFORMATION

I hereby apply for all non-contributory coverages under my employer's plan and any contributory coverages that I have elected on the front of this application.

HSA Pre-enrollment Statements

WARNING: You cannot open an HSA if, in addition to coverage under an HSA-qualified High Deductible Health Plan ("HDHP"), you are also covered under a Health FSA or an HRA or any other health coverage that is not an HDHP.

By checking the HDHP-HSA box in this Medical Enrollment Form, I express my intent to open a Health Savings Account (HSA) with Bank of New York Mellon, Health Savings Account (HSA) Solution℠, an HSA service provider arranged by CIGNA or any other successor HSA service provider arranged by CIGNA (hereafter "the HSA Service Provider"). The HSA Service Provider will contact me and provide me with an HSA enrollment form, a signature card, a request for information for Customer Identification Program compliance and other related materials necessary to activate an HSA account with the HSA Service Provider. I understand that, in order for my HSA opened with the HSA Service Provider to become operational, I must: 1) in a timely manner, complete, sign and submit all the forms required by the HSA Service Provider; and 2) be found to meet all of the requirements prescribed by the HSA Service Provider.

However, if my employer has **not** selected Bank of New York Mellon, Health Savings Account (HSA) Solution℠ as the HSA service provider, I express my intent to open the HSA with an HSA custodian/trustee that is either arranged by my employer or that I personally select. I agree to complete necessary forms and meet the requirements set forth by the HSA custodian/trustee to enable my HSA to become operational.

I understand that, with respect to my HSA opened pursuant to this arrangement, the HSA trustee/custodian will be solely responsible for all HSA services, transactions and activities related thereto. Neither my employer nor CIGNA is responsible for any aspects of the HSA services, administration and operation.

I certify that I have enrolled or plan to enroll under an HDHP and am not covered under any other health coverage that is not an HDHP.

HRA PPO Plan

HRA coverage can only be chosen together with the HRA PPO Plan option. Your HRA coverage is self-funded by your employer, who is solely responsible for contributing the funds used to pay HRA benefits. You are not required to make any contribution to the HRA account, either pursuant to a salary deduction election or otherwise under a Section 125 cafeteria plan (except that contributions are required from those under COBRA continuation coverage). You may not enroll under this option if you are considered self-employed (including partners and more-than-2% shareholders in a subchapter S corporation).

Health coverage

I understand that I must submit a Certificate or evidence of prior creditable coverage to receive credit towards the satisfaction of any pre-existing condition limitation specified in my employer's plan; and to be eligible for credit, the gap between the two coverages must be 63 days or less.

I and/or my eligible dependent(s) will be considered a *"Special Applicant"* if:

- I did not previously elect to cover myself and/or my eligible dependent(s) under my employer's policy/plan because of other health coverage and I later apply because the other coverage terminated due to exhausting the maximum of COBRA coverage or due to loss of eligibility for coverage due to legal separation, divorce, death, termination of employment or reduction in the number of hours of employment; or
- I did not previously elect to cover myself and/or my eligible dependent(s) and I later apply for coverage because of a change in my family status resulting from marriage, birth or adoption or placement for adoption of a child, or a court has ordered me to provide coverage for my dependents; or

I understand that to qualify as a *"Special Applicant"* I must apply for health coverage for myself and/or my eligible dependent(s) within 31 days after:

- Coverage under the prior health plan ends; or I marry; or I acquire a new child through birth, adoption or placement of a child for adoption.

I will be considered a late applicant if:

- I fail to qualify as a *"Special Applicant"* because I did not apply within the 31 days as specified above; or
- I did not previously elect to cover myself and/or my eligible dependents and I later apply.
- My employer offers multiple health plans and I have decided to elect a different plan during the open enrollment period.

As a late applicant applying for health coverage, I realize that I may only be allowed entrance to the plan during the open enrollment period. As a late applicant, I realize that my entry to the plan may be subject to special enrollment requirements and that I must contact my Plan Administrator for details.

For all coverages

Caution: Any person who, knowingly and with intent to defraud any insurance company or other person: (1) files an application for insurance or statement of claim containing any materially false information; or (2) conceals for the purpose of misleading, information concerning any material fact thereto, commits a fraudulent insurance act.

Colorado Residents: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

District of Columbia Residents: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

Florida Residents: 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, incomplete, or misleading information is guilty of a felony of the third degree.

Kentucky Residents: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

Maryland Residents: Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

New Jersey Residents: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

New York Residents: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Oklahoma residents: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

Oregon Residents: Any person who knowingly and with intent to defraud any insurance company or other person: (1) files an application for insurance or statement of claim containing any materially false information; or (2) conceals for the purpose of misleading, information concerning any material fact, may have committed a fraudulent insurance act.

Pennsylvania Residents: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Tennessee Residents: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

Texas Residents: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Virginia Residents: Any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated state law.