CIGNA Dental Enrollment Form

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

CIGNA Dental Health, Inc.
Insured dental plans underwritten by
Connecticut General Life Insurance Company
P.O. Box 22170
Tempe, AZ 85285-2170

CIGNA Dental

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: Hempstead Public Schools | EMPLOYER ADDRESS: 185 Peninsula Blvd Hempstead, NY 11550

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 Employee 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
- ☐ Address Change
- ☐ Transfer to COBRA
  - ☐ 18 mos. ☐ 29 mos. ☐ 36 mos.
- ☐ 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) ☐ Yes ☐ No

SELECT PLAN: ☐ CIGNA Dental Care ☐ CIGNA Dental PPO ☐ CIGNA Dental EPO ☐ 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)
Employee	sss		☐ M ☐ F		1st Choice - 2nd Choice -		☐ Add ☐ Cancel
Spouse	eee		☐ 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

Please submit proof of student or handicapped status for overage 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

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.