



Employee Enrollment Form

Change Type

<input type="checkbox"/> New Hire	<input type="checkbox"/> Qualifying Life Event
<input type="checkbox"/> Open Enrollment	Employer

Member Information

First Name		MI	Last Name	
SSN	DOB	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Marital Status	
Home Address		City	State	Zip Code
Phone	Date Of Hire	Hours Per Wk	Email	

Product/Plan Selection Medical/Rx Plan Options

<input type="checkbox"/> \$1,000	<input type="checkbox"/> \$3,500	<input type="checkbox"/> \$5,000	<input type="checkbox"/> \$7,350
<input type="checkbox"/> Employee Only	<input type="checkbox"/> Employee/Spouse	<input type="checkbox"/> Employee/Child(Ren)	<input type="checkbox"/> Family
Network: CIGNA		Requested Effective Date	



Dependent Information

<input type="checkbox"/> Add Dependent		<input type="checkbox"/> Remove Dependent	
First Name		MI	Last Name
SSN	DOB	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Relationship
First Name		MI	Last Name
SSN	DOB	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Relationship
First Name		MI	Last Name
SSN	DOB	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Relationship
First Name		MI	Last Name
SSN	DOB	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Relationship
First Name		MI	Last Name
SSN	DOB	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Relationship

Significant Terms, Conditions, And Authorizations (Terms)

Please read this section carefully before signing the application

¹ I may not assign any payment under this program.

² I authorize deduction from my wages/pension, if necessary for the required premium for the coverage for which I, or any dependents have applied.

³ I am applying for the coverage selected on this application. If I select a coverage not available to me and/or a class of which I am not eligible, I agree that my selection(s) is hereby automatically amended to be consistent with the employer's application.

⁴ I am responsible to timely notify my employer of any change that would make me or any dependent ineligible for coverage.



I acknowledge that I have read the Significant Terms, Conditions and Authorizations, and I accept such provisions as a condition of coverage. I also acknowledge that the healthcare fees for this plan are deducted pre-tax, requiring the deductions to remain in effect during the plan year, unless there is a change of status as allowed under IRS regulations. I represent that the answers given to all questions on this application are true and accurate to the best of my knowledge and I understand they are being relied on in accepting this application. I understand that any misstatements or failure to report new medical information prior to my effective date may result in cancellation of my coverage(s).

Any person who, with intent to defraud or knowing that he or she is facilitating fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud. I give this authorization for and on behalf of any eligible dependents and myself if covered by the Plan. I am acting as their agent and representative. Read the TERMS section above carefully before signing. Please review your application for errors or omissions.

Read the TERMS section above carefully before signing. Please review your application for errors or omissions.

By signing this, I am indicating that I have read and understand the language in the TERMS section of this application and agree to all of its terms.

Authorized Signature	Date
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