



CIGNA HealthCare

# MEMBERSHIP APPLICATION & CHANGE FORM

## WELCOME TO CIGNA HEALTHCARE!

- Please be sure to complete this Membership Application & Change Form (Membership Application) in its entirety and retain the PINK copy as it will serve as your temporary ID Card. All (applicable) sections of the Membership Application must be complete in order for CIGNA HealthCare to process your Membership Application. Failure to complete the Membership Application will delay the commencement of coverage.
- When filling-out this Membership Application, please be sure to also complete a Standardized Health Form. The Standardized Health Form should be sent to CIGNA HealthCare at PO Box 2041, Concord, NH 03302-2041. If you don't have a copy, your employer can provide one to you or you can download the form from our website:
  - www.cigna.com/health/producer/smallgroup/
  - Select "New Hampshire" from the drop-down menu on the left.
  - Select "Document Library" from the center of the page.
  - Select "Standardized Health Form (SHF)" under "New Hampshire New Group Documents."
- Be sure to complete all sections of the Standardized Health

Form (with the exception of Policy/Group Number (in Section One) for groups new to CIGNA HealthCare).

- You must complete and return the Membership Application (to your employer) and the Standardized Health Form (to CIGNA HealthCare) within 31 days of your proposed effective date of coverage. Failure to do so will delay the commencement of coverage.
- If you are enrolling a dependent(s) age 19 or older, please complete the Dependent(s) Age 19 or Older Questionnaire attached to the back of this Membership Application. Please return the completed Questionnaire to your employer/benefits manager within 31 days of your proposed effective date of coverage. Dependent(s) Age 19 or Older also must complete a Standardized Health Form. The Standardized Health Form should be returned to CIGNA HealthCare at PO Box 2041, Concord, NH 03302-2041, within 31 days of your proposed effective date.
- When you join a CIGNA HealthCare plan, each member of your family must choose a Primary Care Physician (PCP) to coordinate medical care. You can access the Provider Directory online at www.cigna.com or call Member Services at 1.800.531.4584 if you need assistance in selecting a PCP.

## HOW TO COMPLETE THIS APPLICATION

- 1 COVERAGE TYPE / SUBSCRIBER INFORMATION**  
The employee should complete this section. If you are joining CIGNA HealthCare for the first time, please check the NEW SUBSCRIBER box.
- 2 SUBSCRIBER AND DEPENDENT(S) INFORMATION**  
Complete this section for yourself, your spouse and any dependent(s) to be covered under the Plan.
- 3 PRIMARY CARE PHYSICIAN (First and Last Name)**  
Indicate your Primary Care Physician (PCP) selection here. You may refer to the Provider Directory in your CIGNA HealthCare packet, access the Provider Directory online at www.cigna.com or call a Member Services Representative at 1.800.531.4584 for assistance in selecting a PCP.
- 4 OTHER DEPENDENT(S) INFORMATION**  
Specific questions for divorced parents with dependents. Complete this section only if applicable.
- 5 OTHER INSURANCE COVERAGE INFORMATION**  
If you are transferring from another Group Health Plan of if you will have other coverage along with this Plan, please complete this section.
- 6 EMPLOYEE SIGNATURE**  
Employee must sign and date this Membership Application.
- 7 EMPLOYER COMPLETE (1-6)**  
After completing sections 1 through 6, return the Membership Application to your employer to fill-in Group Number, Date of Employment, Comments, Effective Date, Signature and Date.
- 8 CIGNA HEALTHCARE COMPLETE (7)**  
To be completed by CIGNA HealthCare.

| CIGNA HealthCare of New Hampshire, Inc.<br>PO Box 2041<br>Concord, NH 03302-2041                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                           | <b>CIGNA HealthCare Membership Application &amp; Change Form</b><br><small>New members MUST also complete a Standardized Health Form. The Standardized Health Form is a condition of enrollment and is required.</small>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                              |                        |                                                           |                                                          |                                                           |                                                          |                                            |                 |                                             |  |  |  |  |  |                                                          |  |                                                          |                                           |  |  |  |  |  |                                                          |  |                                                          |                                              |  |                                                          |  |  |                                                          |                                                          |  |                                                          |                                              |  |                                                          |  |  |                                                          |                                                          |  |                                                          |                                              |  |                                                          |  |  |                                                          |                                                          |  |                                                          |                                                                                                                                                                                                                                                                    |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------|------------------------|-----------------------------------------------------------|----------------------------------------------------------|-----------------------------------------------------------|----------------------------------------------------------|--------------------------------------------|-----------------|---------------------------------------------|--|--|--|--|--|----------------------------------------------------------|--|----------------------------------------------------------|-------------------------------------------|--|--|--|--|--|----------------------------------------------------------|--|----------------------------------------------------------|----------------------------------------------|--|----------------------------------------------------------|--|--|----------------------------------------------------------|----------------------------------------------------------|--|----------------------------------------------------------|----------------------------------------------|--|----------------------------------------------------------|--|--|----------------------------------------------------------|----------------------------------------------------------|--|----------------------------------------------------------|----------------------------------------------|--|----------------------------------------------------------|--|--|----------------------------------------------------------|----------------------------------------------------------|--|----------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| Group # _____ Subscriber# _____ Effective Date _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                           | CIGNA HealthCare Use Only                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                              |                        |                                                           |                                                          |                                                           |                                                          |                                            |                 |                                             |  |  |  |  |  |                                                          |  |                                                          |                                           |  |  |  |  |  |                                                          |  |                                                          |                                              |  |                                                          |  |  |                                                          |                                                          |  |                                                          |                                              |  |                                                          |  |  |                                                          |                                                          |  |                                                          |                                              |  |                                                          |  |  |                                                          |                                                          |  |                                                          |                                                                                                                                                                                                                                                                    |  |
| <b>(1) CHECK DESIRED COVERAGE TYPE</b><br><input type="checkbox"/> HMO <input type="checkbox"/> MEMBER SELECT <input type="checkbox"/> POS<br><small>Every option may not be available to you. Please verify that your group is offering the coverage you wish to select.</small>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                           | <b>(1) SUBSCRIBER INFORMATION (EMPLOYEE INFORMATION)</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                              |                        |                                                           |                                                          |                                                           |                                                          |                                            |                 |                                             |  |  |  |  |  |                                                          |  |                                                          |                                           |  |  |  |  |  |                                                          |  |                                                          |                                              |  |                                                          |  |  |                                                          |                                                          |  |                                                          |                                              |  |                                                          |  |  |                                                          |                                                          |  |                                                          |                                              |  |                                                          |  |  |                                                          |                                                          |  |                                                          |                                                                                                                                                                                                                                                                    |  |
| <b>CHECK REASON FOR COMPLETING APPLICATION</b><br><input type="checkbox"/> New Subscriber<br><input type="checkbox"/> Name Change <input type="checkbox"/> Address Change<br><input type="checkbox"/> Primary Care Physician Change<br><input type="checkbox"/> Election of COBRA Coverage<br><input type="checkbox"/> Enroll a Family Member<br><input type="checkbox"/> Disenroll a Family Member<br><input type="checkbox"/> Cancellation of Policy<br><input type="checkbox"/> Conversion to Nongroup<br><input type="checkbox"/> Waiver of Insurance Election<br>Explanation of Change _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                           | Last _____ First _____ MI _____<br>Home Address: If the address is a PO Box, please also indicate street address, City _____ State _____ Zip _____<br>Company Name _____<br>Telephone: Home _____ Work _____<br>STATUS (Check) <input type="checkbox"/> Single <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed<br>Type of Coverage Requested <input type="checkbox"/> Individual <input type="checkbox"/> Couple <input type="checkbox"/> Parent/Children <input type="checkbox"/> Family                                                                                                                                                                                                                   |                              |                        |                                                           |                                                          |                                                           |                                                          |                                            |                 |                                             |  |  |  |  |  |                                                          |  |                                                          |                                           |  |  |  |  |  |                                                          |  |                                                          |                                              |  |                                                          |  |  |                                                          |                                                          |  |                                                          |                                              |  |                                                          |  |  |                                                          |                                                          |  |                                                          |                                              |  |                                                          |  |  |                                                          |                                                          |  |                                                          |                                                                                                                                                                                                                                                                    |  |
| <b>(2) SUBSCRIBER AND DEPENDENT(S) INFORMATION</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                           | <b>(3) PRIMARY CARE PHYSICIAN</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                              |                        |                                                           |                                                          |                                                           |                                                          |                                            |                 |                                             |  |  |  |  |  |                                                          |  |                                                          |                                           |  |  |  |  |  |                                                          |  |                                                          |                                              |  |                                                          |  |  |                                                          |                                                          |  |                                                          |                                              |  |                                                          |  |  |                                                          |                                                          |  |                                                          |                                              |  |                                                          |  |  |                                                          |                                                          |  |                                                          |                                                                                                                                                                                                                                                                    |  |
| <table border="1"> <thead> <tr> <th>NAME (First, Mid., Last)</th> <th>Date of Birth (Mo/Day/Yr)</th> <th>Relation to Subscriber</th> <th>Resides in Subscriber's Home</th> <th>Sex (M/F)</th> <th>If dependent is over 19, check Full-time Student Disabled</th> <th>Transferring Coverage from Another Carrier</th> <th>Primary Care Physician (First &amp; Last Name)</th> <th>Current Patient</th> </tr> </thead> <tbody> <tr> <td>01 EMPLOYEE NAME<br/>Social Security # _____</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td><input type="checkbox"/> Yes <input type="checkbox"/> No</td> <td></td> <td><input type="checkbox"/> Yes <input type="checkbox"/> No</td> </tr> <tr> <td>02 SPOUSE NAME<br/>Social Security # _____</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td><input type="checkbox"/> Yes <input type="checkbox"/> No</td> <td></td> <td><input type="checkbox"/> Yes <input type="checkbox"/> No</td> </tr> <tr> <td>03 DEPENDENT NAME<br/>Social Security # _____</td> <td></td> <td>Yes <input type="checkbox"/> No <input type="checkbox"/></td> <td></td> <td></td> <td><input type="checkbox"/> Yes <input type="checkbox"/> No</td> <td><input type="checkbox"/> Yes <input type="checkbox"/> No</td> <td></td> <td><input type="checkbox"/> Yes <input type="checkbox"/> No</td> </tr> <tr> <td>04 DEPENDENT NAME<br/>Social Security # _____</td> <td></td> <td>Yes <input type="checkbox"/> No <input type="checkbox"/></td> <td></td> <td></td> <td><input type="checkbox"/> Yes <input type="checkbox"/> No</td> <td><input type="checkbox"/> Yes <input type="checkbox"/> No</td> <td></td> <td><input type="checkbox"/> Yes <input type="checkbox"/> No</td> </tr> <tr> <td>05 DEPENDENT NAME<br/>Social Security # _____</td> <td></td> <td>Yes <input type="checkbox"/> No <input type="checkbox"/></td> <td></td> <td></td> <td><input type="checkbox"/> Yes <input type="checkbox"/> No</td> <td><input type="checkbox"/> Yes <input type="checkbox"/> No</td> <td></td> <td><input type="checkbox"/> Yes <input type="checkbox"/> No</td> </tr> </tbody> </table> |                           | NAME (First, Mid., Last)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | Date of Birth (Mo/Day/Yr)    | Relation to Subscriber | Resides in Subscriber's Home                              | Sex (M/F)                                                | If dependent is over 19, check Full-time Student Disabled | Transferring Coverage from Another Carrier               | Primary Care Physician (First & Last Name) | Current Patient | 01 EMPLOYEE NAME<br>Social Security # _____ |  |  |  |  |  | <input type="checkbox"/> Yes <input type="checkbox"/> No |  | <input type="checkbox"/> Yes <input type="checkbox"/> No | 02 SPOUSE NAME<br>Social Security # _____ |  |  |  |  |  | <input type="checkbox"/> Yes <input type="checkbox"/> No |  | <input type="checkbox"/> Yes <input type="checkbox"/> No | 03 DEPENDENT NAME<br>Social Security # _____ |  | Yes <input type="checkbox"/> No <input type="checkbox"/> |  |  | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |  | <input type="checkbox"/> Yes <input type="checkbox"/> No | 04 DEPENDENT NAME<br>Social Security # _____ |  | Yes <input type="checkbox"/> No <input type="checkbox"/> |  |  | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |  | <input type="checkbox"/> Yes <input type="checkbox"/> No | 05 DEPENDENT NAME<br>Social Security # _____ |  | Yes <input type="checkbox"/> No <input type="checkbox"/> |  |  | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |  | <input type="checkbox"/> Yes <input type="checkbox"/> No | Please use the Provider Directory to choose a Primary Care Physician for yourself and each of your covered dependent(s).<br><small>If your dependent(s) is/are age 19 or older, complete the form attached to the back of this application within 30 days.</small> |  |
| NAME (First, Mid., Last)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | Date of Birth (Mo/Day/Yr) | Relation to Subscriber                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | Resides in Subscriber's Home | Sex (M/F)              | If dependent is over 19, check Full-time Student Disabled | Transferring Coverage from Another Carrier               | Primary Care Physician (First & Last Name)                | Current Patient                                          |                                            |                 |                                             |  |  |  |  |  |                                                          |  |                                                          |                                           |  |  |  |  |  |                                                          |  |                                                          |                                              |  |                                                          |  |  |                                                          |                                                          |  |                                                          |                                              |  |                                                          |  |  |                                                          |                                                          |  |                                                          |                                              |  |                                                          |  |  |                                                          |                                                          |  |                                                          |                                                                                                                                                                                                                                                                    |  |
| 01 EMPLOYEE NAME<br>Social Security # _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                              |                        |                                                           | <input type="checkbox"/> Yes <input type="checkbox"/> No |                                                           | <input type="checkbox"/> Yes <input type="checkbox"/> No |                                            |                 |                                             |  |  |  |  |  |                                                          |  |                                                          |                                           |  |  |  |  |  |                                                          |  |                                                          |                                              |  |                                                          |  |  |                                                          |                                                          |  |                                                          |                                              |  |                                                          |  |  |                                                          |                                                          |  |                                                          |                                              |  |                                                          |  |  |                                                          |                                                          |  |                                                          |                                                                                                                                                                                                                                                                    |  |
| 02 SPOUSE NAME<br>Social Security # _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                              |                        |                                                           | <input type="checkbox"/> Yes <input type="checkbox"/> No |                                                           | <input type="checkbox"/> Yes <input type="checkbox"/> No |                                            |                 |                                             |  |  |  |  |  |                                                          |  |                                                          |                                           |  |  |  |  |  |                                                          |  |                                                          |                                              |  |                                                          |  |  |                                                          |                                                          |  |                                                          |                                              |  |                                                          |  |  |                                                          |                                                          |  |                                                          |                                              |  |                                                          |  |  |                                                          |                                                          |  |                                                          |                                                                                                                                                                                                                                                                    |  |
| 03 DEPENDENT NAME<br>Social Security # _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                           | Yes <input type="checkbox"/> No <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                              |                        | <input type="checkbox"/> Yes <input type="checkbox"/> No  | <input type="checkbox"/> Yes <input type="checkbox"/> No |                                                           | <input type="checkbox"/> Yes <input type="checkbox"/> No |                                            |                 |                                             |  |  |  |  |  |                                                          |  |                                                          |                                           |  |  |  |  |  |                                                          |  |                                                          |                                              |  |                                                          |  |  |                                                          |                                                          |  |                                                          |                                              |  |                                                          |  |  |                                                          |                                                          |  |                                                          |                                              |  |                                                          |  |  |                                                          |                                                          |  |                                                          |                                                                                                                                                                                                                                                                    |  |
| 04 DEPENDENT NAME<br>Social Security # _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                           | Yes <input type="checkbox"/> No <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                              |                        | <input type="checkbox"/> Yes <input type="checkbox"/> No  | <input type="checkbox"/> Yes <input type="checkbox"/> No |                                                           | <input type="checkbox"/> Yes <input type="checkbox"/> No |                                            |                 |                                             |  |  |  |  |  |                                                          |  |                                                          |                                           |  |  |  |  |  |                                                          |  |                                                          |                                              |  |                                                          |  |  |                                                          |                                                          |  |                                                          |                                              |  |                                                          |  |  |                                                          |                                                          |  |                                                          |                                              |  |                                                          |  |  |                                                          |                                                          |  |                                                          |                                                                                                                                                                                                                                                                    |  |
| 05 DEPENDENT NAME<br>Social Security # _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                           | Yes <input type="checkbox"/> No <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                              |                        | <input type="checkbox"/> Yes <input type="checkbox"/> No  | <input type="checkbox"/> Yes <input type="checkbox"/> No |                                                           | <input type="checkbox"/> Yes <input type="checkbox"/> No |                                            |                 |                                             |  |  |  |  |  |                                                          |  |                                                          |                                           |  |  |  |  |  |                                                          |  |                                                          |                                              |  |                                                          |  |  |                                                          |                                                          |  |                                                          |                                              |  |                                                          |  |  |                                                          |                                                          |  |                                                          |                                              |  |                                                          |  |  |                                                          |                                                          |  |                                                          |                                                                                                                                                                                                                                                                    |  |
| <b>(4) OTHER DEPENDENT(S) INFORMATION</b><br>Dependent(s) of Legally Divorced Parents: <input type="checkbox"/> Natural Mother <input type="checkbox"/> Natural Father <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Parent Name _____<br>If yes, indicate effective date and name of insurance company _____<br>Dependent Address (if different): No. & Street _____ Home Telephone ( ) _____<br>City _____ State _____ Zip Code _____ Work Telephone ( ) _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                           | <b>(5) OTHER INSURANCE COVERAGE INFORMATION</b><br>Do you or your family have health coverage through another group or employer? <input type="checkbox"/> Yes <input type="checkbox"/> No<br>Names of individuals who have other coverage: _____ Policyholder _____ Policy # _____<br>Name of Insurance Company _____<br>Is spouse employed? <input type="checkbox"/> Yes <input type="checkbox"/> No<br>Is there a divorce decree establishing insurance responsibility? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please provide CIGNA HealthCare the portion of the decree which states this responsibility. (Disregard if previously sent).<br>Name of Insurance Co. _____<br>Policy Number _____ Effective Date _____ Term Date _____ |                              |                        |                                                           |                                                          |                                                           |                                                          |                                            |                 |                                             |  |  |  |  |  |                                                          |  |                                                          |                                           |  |  |  |  |  |                                                          |  |                                                          |                                              |  |                                                          |  |  |                                                          |                                                          |  |                                                          |                                              |  |                                                          |  |  |                                                          |                                                          |  |                                                          |                                              |  |                                                          |  |  |                                                          |                                                          |  |                                                          |                                                                                                                                                                                                                                                                    |  |
| In completing this Application, I agree to the following for myself and all eligible dependent(s):<br>1. That any hospital or physician may furnish CIGNA HealthCare such medical information as may be required to conduct a professional utilization review program of health services, and to coordinate benefits and/or reimbursements with other health or insurance programs.<br>2. I acknowledge that copies of the CIGNA HealthCare Group Subscriber Agreement and Provider Directory are available with my employer for my review and understand that the benefits for which I will be eligible are those described in the Group Subscriber Agreement.<br>3a. <b>HMO &amp; MEMBER SELECT ONLY:</b> I fully understand that my (our) Primary Care Physician(s) must provide or authorize all medical and hospital care except in a medical emergency.<br>3b. <b>POS ONLY:</b> I fully understand that to receive reimbursement at the in-network benefit payment level my Primary Care Physician must provide or authorize all medical and hospital care except in a medical emergency.<br>4. That any dispute or claim be resolved according to the Grievance Procedures Section of the Group Subscriber Agreement.<br>5. That all information furnished by me is true and complete to the best of my knowledge.<br>6. That my Membership Application will not be considered complete unless all applicable information is provided within 31 days of my proposed effective date. I further understand that, in conjunction with this Membership Application, I must also complete and submit a Standardized Health Form to CIGNA HealthCare within 31 days of my proposed effective date. I fully understand that my coverage may be affected if I fail to provide a completed Membership Application and Standardized Health Form within 31 days of my proposed effective date.                                                                                                                                                                                                                                           |                           | <b>(6) Employee Signature:</b> _____ <b>Date:</b> _____<br><b>(7) EMPLOYER COMPLETE 1 - 6</b><br>1. GROUP NUMBER _____ 2. DATE OF EMPLOYMENT _____ 3. COMMENTS _____<br>4. COMPANY REPRESENTATIVE SIGNATURE _____ 5. DATE _____<br>6. DATE _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                              |                        |                                                           |                                                          |                                                           |                                                          |                                            |                 |                                             |  |  |  |  |  |                                                          |  |                                                          |                                           |  |  |  |  |  |                                                          |  |                                                          |                                              |  |                                                          |  |  |                                                          |                                                          |  |                                                          |                                              |  |                                                          |  |  |                                                          |                                                          |  |                                                          |                                              |  |                                                          |  |  |                                                          |                                                          |  |                                                          |                                                                                                                                                                                                                                                                    |  |
| 576669a 02/06 ©2006 CIGNA MKFHMOSSLAPP 02/06 CIGNA HEALTHCARE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                           | <b>(8) CIGNA HEALTHCARE COMPLETE 7</b><br>7. DATE ENTERED _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                              |                        |                                                           |                                                          |                                                           |                                                          |                                            |                 |                                             |  |  |  |  |  |                                                          |  |                                                          |                                           |  |  |  |  |  |                                                          |  |                                                          |                                              |  |                                                          |  |  |                                                          |                                                          |  |                                                          |                                              |  |                                                          |  |  |                                                          |                                                          |  |                                                          |                                              |  |                                                          |  |  |                                                          |                                                          |  |                                                          |                                                                                                                                                                                                                                                                    |  |

Questions? For HMO & MEMBER SELECT please call us at 1.800.291.2466, for Point-of-Service (POS) please call us at 1.800.531.4005, Monday through Friday, 8:00 am - 6:00 pm.

# CIGNA HealthCare Membership Application & Change Form

New members **MUST** also complete a Standardized Health Form. The Standardized Health Form is a condition of enrollment and is required.

## CIGNA HealthCare Use Only.

Group # \_\_\_\_\_ Subscriber# \_\_\_\_\_ Effective Date \_\_\_\_\_

### (1) CHECK DESIRED COVERAGE TYPE

HMO  MEMBER SELECT  POS  
 Every option may not be available to you. Please verify that your group is offering the coverage you wish to select.

#### CHECK REASON FOR COMPLETING APPLICATION

- New Subscriber
  - Name Change  Address Change
  - Primary Care Physician Change
  - Election of COBRA Coverage
  - Enroll a Family Member
  - Disenroll a Family Member
  - Cancellation of Policy
  - Conversion to Nongroup
  - Waiver of Insurance Election
- Explanation of Change \_\_\_\_\_

### (1) SUBSCRIBER INFORMATION (EMPLOYEE INFORMATION)

|                                                                                            |                                    |                                                                              |
|--------------------------------------------------------------------------------------------|------------------------------------|------------------------------------------------------------------------------|
| Last                                                                                       | First                              | MI                                                                           |
| Home Address: <i>If the address is a PO Box, please also indicate street address.</i> City |                                    | State Zip                                                                    |
| Company Name                                                                               |                                    |                                                                              |
| Telephone: Home                                                                            | Work                               |                                                                              |
| ( )                                                                                        | ( )                                |                                                                              |
| STATUS (Check)                                                                             |                                    | Type of Coverage Requested                                                   |
| <input type="checkbox"/> Single                                                            | <input type="checkbox"/> Separated | <input type="checkbox"/> Individual <input type="checkbox"/> Parent/Children |
| <input type="checkbox"/> Married                                                           | <input type="checkbox"/> Divorced  | <input type="checkbox"/> Couple <input type="checkbox"/> Family              |
| <input type="checkbox"/> Widowed                                                           | <input type="checkbox"/> Retired   |                                                                              |

Please use the Provider Directory to choose a Primary Care Physician for yourself and each of your covered dependent(s). If your dependent(s) is/are age 19 or older complete the form attached to the back of this application within 30 days.

### (2) SUBSCRIBER AND DEPENDENT(S) INFORMATION

### (3) PRIMARY CARE PHYSICIAN

| NAME (First, Mid., Last)<br><i>Social Security Number for Employee, Spouse and Dependent(s) required for processing.</i> | Date of Birth<br>Mo/Day/Yr | Relation to<br>Subscriber | Resides in<br>Subscriber's<br>Home                          | Sex<br>M/F | If dependent is<br>over 19, check |                          | Transferring<br>Coverage<br>from Another<br>Carrier         | Primary Care Physician<br>(First & Last Name) | Current<br>Patient                                          |
|--------------------------------------------------------------------------------------------------------------------------|----------------------------|---------------------------|-------------------------------------------------------------|------------|-----------------------------------|--------------------------|-------------------------------------------------------------|-----------------------------------------------|-------------------------------------------------------------|
|                                                                                                                          |                            |                           |                                                             |            | Full-time<br>Student              | Disabled                 |                                                             |                                               |                                                             |
| 01 EMPLOYEE NAME                                                                                                         |                            |                           |                                                             |            |                                   |                          | Yes <input type="checkbox"/><br>No <input type="checkbox"/> |                                               | Yes <input type="checkbox"/><br>No <input type="checkbox"/> |
| <i>Social Security #</i>                                                                                                 |                            |                           |                                                             |            |                                   |                          |                                                             |                                               |                                                             |
| 02 SPOUSE NAME                                                                                                           |                            |                           |                                                             |            |                                   |                          | Yes <input type="checkbox"/><br>No <input type="checkbox"/> |                                               | Yes <input type="checkbox"/><br>No <input type="checkbox"/> |
| <i>Social Security #</i>                                                                                                 |                            |                           |                                                             |            |                                   |                          |                                                             |                                               |                                                             |
| 03 DEPENDENT NAME                                                                                                        |                            |                           | Yes <input type="checkbox"/><br>No <input type="checkbox"/> |            | <input type="checkbox"/>          | <input type="checkbox"/> | Yes <input type="checkbox"/><br>No <input type="checkbox"/> |                                               | Yes <input type="checkbox"/><br>No <input type="checkbox"/> |
| <i>Social Security #</i>                                                                                                 |                            |                           |                                                             |            |                                   |                          |                                                             |                                               |                                                             |
| 04 DEPENDENT NAME                                                                                                        |                            |                           | Yes <input type="checkbox"/><br>No <input type="checkbox"/> |            | <input type="checkbox"/>          | <input type="checkbox"/> | Yes <input type="checkbox"/><br>No <input type="checkbox"/> |                                               | Yes <input type="checkbox"/><br>No <input type="checkbox"/> |
| <i>Social Security #</i>                                                                                                 |                            |                           |                                                             |            |                                   |                          |                                                             |                                               |                                                             |
| 05 DEPENDENT NAME                                                                                                        |                            |                           | Yes <input type="checkbox"/><br>No <input type="checkbox"/> |            | <input type="checkbox"/>          | <input type="checkbox"/> | Yes <input type="checkbox"/><br>No <input type="checkbox"/> |                                               | Yes <input type="checkbox"/><br>No <input type="checkbox"/> |
| <i>Social Security #</i>                                                                                                 |                            |                           |                                                             |            |                                   |                          |                                                             |                                               |                                                             |

### (4) OTHER DEPENDENT(S) INFORMATION

Dependent(s) of Legally Divorced Parents: \_\_\_\_\_ Does the dependent(s) have other group insurance? \_\_\_\_\_  
 Who does the child reside with?  Natural Mother  Natural Father  Yes  No Parent Name \_\_\_\_\_  
 If yes, indicate effective date and name of insurance Company \_\_\_\_\_  
 Dependent Address (if different): No. & Street \_\_\_\_\_ Home Telephone ( ) \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_ Work Telephone ( ) \_\_\_\_\_

### (5) OTHER INSURANCE COVERAGE INFORMATION

|                                                                                                                                                                                                                                                               |                                                                                                                                                                                                                                                          |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Do you or your family have health coverage through another group or employer? <input type="checkbox"/> Yes <input type="checkbox"/> No _____                                                                                                                  | To join CIGNA HealthCare are you transferring your coverage from any other carrier? <input type="checkbox"/> Yes <input type="checkbox"/> No<br>Name _____<br>Name of Insurance Co. _____<br>Policy Number _____<br>Effective Date _____ Term Date _____ |
| Names of individuals who have other coverage _____                                                                                                                                                                                                            |                                                                                                                                                                                                                                                          |
| Name of Insurance Company _____ Policyholder _____ Policy # _____                                                                                                                                                                                             |                                                                                                                                                                                                                                                          |
| Is spouse employed? <input type="checkbox"/> Yes <input type="checkbox"/> No _____                                                                                                                                                                            |                                                                                                                                                                                                                                                          |
| Is there a divorce decree establishing insurance responsibility? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please provide CIGNA HealthCare the portion of the decree which states this responsibility, (Disregard if previously sent). |                                                                                                                                                                                                                                                          |

- In completing this Application, I agree to the following for myself and all eligible dependent(s):
- That any hospital or physician may furnish CIGNA HealthCare such medical information as may be required to conduct a professional utilization review program of health services, and to coordinate benefits and/or reimbursements with other health or insurance programs.
  - I acknowledge that copies of the CIGNA HealthCare Group Subscriber Agreement and Provider Directory are available with my employer for my review and understand that the benefits for which (we) will be eligible are those described in the Group Subscriber Agreement.
  - HMO & MEMBER SELECT ONLY:** I (we) fully understand that my (our) Primary Care Physician(s) must provide or authorize all medical and hospital care except in a medical emergency.
  - POS ONLY:** I fully understand that to receive reimbursement at the in-network benefit payment level my Primary Care Physician must provide or authorize all medical and hospital care except in a medical emergency.
  - That any dispute or claim be resolved according to the Grievance Procedures Section of the Group Subscriber Agreement.
  - That all information furnished by me is true and complete to the best of my knowledge.
  - That my Membership Application will not be considered complete unless all applicable information is provided within 31 days of my proposed effective date. I further understand that, in conjunction with this Membership Application, I must also complete and submit a Standardized Health Form to CIGNA HealthCare within 31 days of my proposed effective date. I fully understand that my coverage may be affected if I fail to provide a completed Membership Application and Standardized Health Form within 31 days of my proposed effective date.

(6) Employee Signature:  X  Date: \_\_\_\_\_

### (7) EMPLOYER COMPLETE 1 - 6

### (8) CIGNA HEALTHCARE COMPLETE 7

|                   |                                     |             |                 |
|-------------------|-------------------------------------|-------------|-----------------|
| 1. GROUP NUMBER   | 3. DATE OF EMPLOYMENT               | 5. COMMENTS | 7. DATE ENTERED |
| 2. EFFECTIVE DATE | 4. COMPANY REPRESENTATIVE SIGNATURE |             | 6. DATE         |



# CIGNA HealthCare Membership Application & Change Form

New members **MUST** also complete a Standardized Health Form. The Standardized Health Form is a condition of enrollment and is required.

## CIGNA HealthCare Use Only.

Group # \_\_\_\_\_ Subscriber# \_\_\_\_\_ Effective Date \_\_\_\_\_

### (1) CHECK DESIRED COVERAGE TYPE

HMO  MEMBER SELECT  POS  
 Every option may not be available to you. Please verify that your group is offering the coverage you wish to select.

#### CHECK REASON FOR COMPLETING APPLICATION

- New Subscriber
- Name Change  Address Change
- Primary Care Physician Change
- Election of COBRA Coverage
- Enroll a Family Member
- Disenroll a Family Member
- Cancellation of Policy
- Conversion to Nongroup
- Waiver of Insurance Election

Explanation of Change \_\_\_\_\_

### (1) SUBSCRIBER INFORMATION (EMPLOYEE INFORMATION)

Last \_\_\_\_\_ First \_\_\_\_\_ MI \_\_\_\_\_

Home Address: If the address is a PO Box, please also indicate street address. City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Company Name \_\_\_\_\_

Telephone: Home \_\_\_\_\_ Work \_\_\_\_\_  
 ( ) ( )

#### STATUS (Check)

- Single  Separated
- Married  Divorced
- Widowed  Retired

#### Type of Coverage Requested

- Individual  Parent/Children
- Couple  Family

Please use the Provider Directory to choose a Primary Care Physician for yourself and each of your covered dependent(s). If your dependent(s) is/are age 19 or older complete the form attached to the back of this application within 30 days.

### (2) SUBSCRIBER AND DEPENDENT(S) INFORMATION

### (3) PRIMARY CARE PHYSICIAN

| NAME (First, Mid., Last)<br><i>Social Security Number for Employee, Spouse and Dependent(s) required for processing.</i> | Date of Birth<br>Mo/Day/Yr | Relation to<br>Subscriber | Resides in<br>Subscriber's<br>Home                          | Sex<br>M/F | If dependent is<br>over 19, check |                          | Transferring<br>Coverage<br>from Another<br>Carrier         | Primary Care Physician<br>(First & Last Name) | Current<br>Patient                                          |
|--------------------------------------------------------------------------------------------------------------------------|----------------------------|---------------------------|-------------------------------------------------------------|------------|-----------------------------------|--------------------------|-------------------------------------------------------------|-----------------------------------------------|-------------------------------------------------------------|
|                                                                                                                          |                            |                           |                                                             |            | Full-time<br>Student              | Disabled                 |                                                             |                                               |                                                             |
| 01 EMPLOYEE NAME<br><i>Social Security #</i>                                                                             |                            |                           |                                                             |            |                                   |                          | Yes <input type="checkbox"/><br>No <input type="checkbox"/> |                                               | Yes <input type="checkbox"/><br>No <input type="checkbox"/> |
| 02 SPOUSE NAME<br><i>Social Security #</i>                                                                               |                            |                           |                                                             |            |                                   |                          | Yes <input type="checkbox"/><br>No <input type="checkbox"/> |                                               | Yes <input type="checkbox"/><br>No <input type="checkbox"/> |
| 03 DEPENDENT NAME<br><i>Social Security #</i>                                                                            |                            |                           | Yes <input type="checkbox"/><br>No <input type="checkbox"/> |            | <input type="checkbox"/>          | <input type="checkbox"/> | Yes <input type="checkbox"/><br>No <input type="checkbox"/> |                                               | Yes <input type="checkbox"/><br>No <input type="checkbox"/> |
| 04 DEPENDENT NAME<br><i>Social Security #</i>                                                                            |                            |                           | Yes <input type="checkbox"/><br>No <input type="checkbox"/> |            | <input type="checkbox"/>          | <input type="checkbox"/> | Yes <input type="checkbox"/><br>No <input type="checkbox"/> |                                               | Yes <input type="checkbox"/><br>No <input type="checkbox"/> |
| 05 DEPENDENT NAME<br><i>Social Security #</i>                                                                            |                            |                           | Yes <input type="checkbox"/><br>No <input type="checkbox"/> |            | <input type="checkbox"/>          | <input type="checkbox"/> | Yes <input type="checkbox"/><br>No <input type="checkbox"/> |                                               | Yes <input type="checkbox"/><br>No <input type="checkbox"/> |

### (4) OTHER DEPENDENT(S) INFORMATION

Dependent(s) of Legally Divorced Parents: \_\_\_\_\_ Does the dependent(s) have other group insurance? \_\_\_\_\_  
 Who does the child reside with?  Natural Mother  Natural Father  Yes  No Parent Name \_\_\_\_\_  
 If yes, indicate effective date and name of insurance Company \_\_\_\_\_  
 Dependent Address (if different): No. & Street \_\_\_\_\_ Home Telephone ( ) \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_ Work Telephone ( ) \_\_\_\_\_

### (5) OTHER INSURANCE COVERAGE INFORMATION

Do you or your family have health coverage through another group or employer?  Yes  No \_\_\_\_\_  
 Names of individuals who have other coverage \_\_\_\_\_  
 Name of Insurance Company \_\_\_\_\_ Policyholder \_\_\_\_\_ Policy # \_\_\_\_\_  
 Is spouse employed?  Yes  No \_\_\_\_\_  
 Is there a divorce decree establishing insurance responsibility?  Yes  No If yes, please provide CIGNA HealthCare the portion of the decree which states this responsibility, (Disregard if previously sent). \_\_\_\_\_  
 To join CIGNA HealthCare are you transferring your coverage from any other carrier?  Yes  No \_\_\_\_\_  
 Name \_\_\_\_\_  
 Name of Insurance Co. \_\_\_\_\_  
 Policy Number \_\_\_\_\_  
 Effective Date \_\_\_\_\_ Term Date \_\_\_\_\_

In completing this Application, I agree to the following for myself and all eligible dependent(s):

- That any hospital or physician may furnish CIGNA HealthCare such medical information as may be required to conduct a professional utilization review program of health services, and to coordinate benefits and/or reimbursements with other health or insurance programs.
- I acknowledge that copies of the CIGNA HealthCare Group Subscriber Agreement and Provider Directory are available with my employer for my review and understand that the benefits for which (we) will be eligible are those described in the Group Subscriber Agreement.
- HMO & MEMBER SELECT ONLY:** I (we) fully understand that my (our) Primary Care Physician(s) must provide or authorize all medical and hospital care except in a medical emergency.
- POS ONLY:** I fully understand that to receive reimbursement at the in-network benefit payment level my Primary Care Physician must provide or authorize all medical and hospital care except in a medical emergency.
- That any dispute or claim be resolved according to the Grievance Procedures Section of the Group Subscriber Agreement.
- That all information furnished by me is true and complete to the best of my knowledge.
- That my Membership Application will not be considered complete unless all applicable information is provided within 31 days of my proposed effective date. I further understand that, in conjunction with this Membership Application, I must also complete and submit a Standardized Health Form to CIGNA HealthCare within 31 days of my proposed effective date. I fully understand that my coverage may be affected if I fail to provide a completed Membership Application and Standardized Health Form within 31 days of my proposed effective date.

(6) Employee Signature: X \_\_\_\_\_ Date: \_\_\_\_\_

### (7) EMPLOYER COMPLETE 1 - 6

### (8) CIGNA HEALTHCARE COMPLETE 7

|                   |                                     |             |                 |
|-------------------|-------------------------------------|-------------|-----------------|
| 1. GROUP NUMBER   | 3. DATE OF EMPLOYMENT               | 5. COMMENTS | 7. DATE ENTERED |
| 2. EFFECTIVE DATE | 4. COMPANY REPRESENTATIVE SIGNATURE | 6. DATE     |                 |

# CIGNA HealthCare Membership Application & Change Form

New members **MUST** also complete a Standardized Health Form. The Standardized Health Form is a condition of enrollment and is required.

## CIGNA HealthCare Use Only.

Group # \_\_\_\_\_ Subscriber# \_\_\_\_\_ Effective Date \_\_\_\_\_

### (1) CHECK DESIRED COVERAGE TYPE

HMO  MEMBER SELECT  POS  
 Every option may not be available to you. Please verify that your group is offering the coverage you wish to select.

#### CHECK REASON FOR COMPLETING APPLICATION

- New Subscriber
- Name Change  Address Change
- Primary Care Physician Change
- Election of COBRA Coverage
- Enroll a Family Member
- Disenroll a Family Member
- Cancellation of Policy
- Conversion to Nongroup
- Waiver of Insurance Election

Explanation of Change \_\_\_\_\_

### (1) SUBSCRIBER INFORMATION (EMPLOYEE INFORMATION)

Last \_\_\_\_\_ First \_\_\_\_\_ MI \_\_\_\_\_

Home Address: If the address is a PO Box, please also indicate street address. City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Company Name \_\_\_\_\_

Telephone: Home \_\_\_\_\_ Work \_\_\_\_\_  
 ( ) ( )

#### STATUS (Check)

- Single  Separated
- Married  Divorced
- Widowed  Retired

#### Type of Coverage Requested

- Individual  Parent/Children
- Couple  Family

Please use the Provider Directory to choose a Primary Care Physician for yourself and each of your covered dependent(s). If your dependent(s) is/are age 19 or older complete the form attached to the back of this application within 30 days.

### (2) SUBSCRIBER AND DEPENDENT(S) INFORMATION

### (3) PRIMARY CARE PHYSICIAN

| NAME (First, Mid., Last)<br><i>Social Security Number for Employee, Spouse and Dependent(s) required for processing.</i> | Date of Birth<br>Mo/Day/Yr | Relation to<br>Subscriber | Resides in<br>Subscriber's<br>Home                          | Sex<br>M/F | If dependent is<br>over 19, check |                          | Transferring<br>Coverage<br>from Another<br>Carrier         | Primary Care Physician<br>(First & Last Name) | Current<br>Patient                                          |
|--------------------------------------------------------------------------------------------------------------------------|----------------------------|---------------------------|-------------------------------------------------------------|------------|-----------------------------------|--------------------------|-------------------------------------------------------------|-----------------------------------------------|-------------------------------------------------------------|
|                                                                                                                          |                            |                           |                                                             |            | Full-time<br>Student              | Disabled                 |                                                             |                                               |                                                             |
| 01 EMPLOYEE NAME<br><i>Social Security #</i>                                                                             |                            |                           |                                                             |            |                                   | <input type="checkbox"/> | Yes <input type="checkbox"/><br>No <input type="checkbox"/> |                                               | Yes <input type="checkbox"/><br>No <input type="checkbox"/> |
| 02 SPOUSE NAME<br><i>Social Security #</i>                                                                               |                            |                           |                                                             |            |                                   | <input type="checkbox"/> | Yes <input type="checkbox"/><br>No <input type="checkbox"/> |                                               | Yes <input type="checkbox"/><br>No <input type="checkbox"/> |
| 03 DEPENDENT NAME<br><i>Social Security #</i>                                                                            |                            |                           | Yes <input type="checkbox"/><br>No <input type="checkbox"/> |            | <input type="checkbox"/>          | <input type="checkbox"/> | Yes <input type="checkbox"/><br>No <input type="checkbox"/> |                                               | Yes <input type="checkbox"/><br>No <input type="checkbox"/> |
| 04 DEPENDENT NAME<br><i>Social Security #</i>                                                                            |                            |                           | Yes <input type="checkbox"/><br>No <input type="checkbox"/> |            | <input type="checkbox"/>          | <input type="checkbox"/> | Yes <input type="checkbox"/><br>No <input type="checkbox"/> |                                               | Yes <input type="checkbox"/><br>No <input type="checkbox"/> |
| 05 DEPENDENT NAME<br><i>Social Security #</i>                                                                            |                            |                           | Yes <input type="checkbox"/><br>No <input type="checkbox"/> |            | <input type="checkbox"/>          | <input type="checkbox"/> | Yes <input type="checkbox"/><br>No <input type="checkbox"/> |                                               | Yes <input type="checkbox"/><br>No <input type="checkbox"/> |

### (4) OTHER DEPENDENT(S) INFORMATION

Dependent(s) of Legally Divorced Parents: \_\_\_\_\_ Does the dependent(s) have other group insurance? \_\_\_\_\_  
 Who does the child reside with?  Natural Mother  Natural Father  Yes  No Parent Name \_\_\_\_\_  
 If yes, indicate effective date and name of insurance Company \_\_\_\_\_  
 Dependent Address (if different): No. & Street \_\_\_\_\_ Home Telephone ( ) \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_ Work Telephone ( ) \_\_\_\_\_

### (5) OTHER INSURANCE COVERAGE INFORMATION

Do you or your family have health coverage through another group or employer?  Yes  No \_\_\_\_\_  
 Names of individuals who have other coverage \_\_\_\_\_  
 Name of Insurance Company \_\_\_\_\_ Policyholder \_\_\_\_\_ Policy # \_\_\_\_\_  
 Is spouse employed?  Yes  No \_\_\_\_\_  
 Is there a divorce decree establishing insurance responsibility?  Yes  No If yes, please provide CIGNA HealthCare the portion of the decree which states this responsibility, (Disregard if previously sent). \_\_\_\_\_  
 To join CIGNA HealthCare are you transferring your coverage from any other carrier?  Yes  No \_\_\_\_\_  
 Name \_\_\_\_\_  
 Name of Insurance Co. \_\_\_\_\_  
 Policy Number \_\_\_\_\_  
 Effective Date \_\_\_\_\_ Term Date \_\_\_\_\_

In completing this Application, I agree to the following for myself and all eligible dependent(s):

- That any hospital or physician may furnish CIGNA HealthCare such medical information as may be required to conduct a professional utilization review program of health services, and to coordinate benefits and/or reimbursements with other health or insurance programs.
- I acknowledge that copies of the CIGNA HealthCare Group Subscriber Agreement and Provider Directory are available with my employer for my review and understand that the benefits for which (we) will be eligible are those described in the Group Subscriber Agreement.
- HMO & MEMBER SELECT ONLY:** I (we) fully understand that my (our) Primary Care Physician(s) must provide or authorize all medical and hospital care except in a medical emergency.
- POS ONLY:** I fully understand that to receive reimbursement at the in-network benefit payment level my Primary Care Physician must provide or authorize all medical and hospital care except in a medical emergency.
- That any dispute or claim be resolved according to the Grievance Procedures Section of the Group Subscriber Agreement.
- That all information furnished by me is true and complete to the best of my knowledge.
- That my Membership Application will not be considered complete unless all applicable information is provided within 31 days of my proposed effective date. I further understand that, in conjunction with this Membership Application, I must also complete and submit a Standardized Health Form to CIGNA HealthCare within 31 days of my proposed effective date. I fully understand that my coverage may be affected if I fail to provide a completed Membership Application and Standardized Health Form within 31 days of my proposed effective date.

(6) Employee Signature:  X  \_\_\_\_\_ Date: \_\_\_\_\_

### (7) EMPLOYER COMPLETE 1 - 6

### (8) CIGNA HEALTHCARE COMPLETE 7

|                   |                                     |             |                 |
|-------------------|-------------------------------------|-------------|-----------------|
| 1. GROUP NUMBER   | 3. DATE OF EMPLOYMENT               | 5. COMMENTS | 7. DATE ENTERED |
| 2. EFFECTIVE DATE | 4. COMPANY REPRESENTATIVE SIGNATURE | 6. DATE     |                 |



## **CIGNA HealthCare**

CIGNA HealthCare of New Hampshire, Inc.  
PO Box 2041  
Concord, NH 03302-2041

**NEW SUBSCRIBER:** Thank you for choosing CIGNA HealthCare. Please keep the pink copy of this Membership Application for your records; it will serve as your temporary ID Card until your actual ID Card is sent to you. As soon as your enrollment becomes effective, CIGNA HealthCare is responsible for providing access to health care services that are covered under your Plan. Please call your Primary Care Physician (PCP) for regular appointments, urgent care and medical emergencies.

**FOR APPOINTMENTS:** Call your Primary Care Physician.

**FOR EMERGENCY CARE:** When appropriate, call your Primary Care Physician and follow the physician's instructions. In the instance of a medical emergency, go to the nearest Emergency Room for care and notify your Primary Care Physician as soon as possible to ensure that your claim is eligible for coverage.

**OUT-OF-AREA CARE:** If you have a medical emergency or urgent care need while you are away from home, you may see any physician for treatment. However, you must notify your Primary Care Physician within 48 hours to ensure that your claim is eligible for coverage and that your PCP coordinates any required follow-up care.

**QUESTIONS:** The CIGNA HealthCare Member Services Department is available to answer your questions. For HMO and MEMBER SELECT Plans, call 1.800.291.2466. For Point-of-Service (POS) Plans, call 1.800.531.4005.

Return to:



CIGNA HealthCare

CIGNA HealthCare of New Hampshire, Inc.

PO Box 2041

Concord, NH 03302-2041

Attn: Enrollment Department

### Dependent(s) Age 19 or Older Questionnaire

Please Print or Type.

New members MUST also complete a Standardized Health Form. The Standardized Health Form is a condition of enrollment and is required.

**PLEASE COMPLETE ONLY THE NECESSARY SECTIONS (A OR B) AND FORWARD TO YOUR SCHOOL (SECTION A) OR PHYSICIAN (SECTION B). PLEASE COMPLETE WITHIN 30 DAYS.**

**A. UNMARRIED FULL-TIME STUDENT**

IF YOUR DEPENDENT IS ATTENDING SCHOOL, PLEASE COMPLETE THE INFORMATION BELOW AND HAVE THE SCHOOL REGISTRAR SIGN AND SEAL THIS FORM.

Employee Name \_\_\_\_\_ Employer Name \_\_\_\_\_

Dependent Name \_\_\_\_\_ Social Security # \_\_\_\_\_

|                                                                          |                   |                             |                                                          |
|--------------------------------------------------------------------------|-------------------|-----------------------------|----------------------------------------------------------|
| Student Status                                                           | Number of Credits | Date Current Semester Began | Student Enrolled Last Semester                           |
| <input type="checkbox"/> Full-Time<br><input type="checkbox"/> Part-Time |                   |                             | <input type="checkbox"/> Yes <input type="checkbox"/> No |

▼ **SEAL AREA** ▼

  
  
  
  
  
  
  
  
  
  

**FORM IS NOT VALID WITHOUT REGISTRAR'S SEAL**

School Name \_\_\_\_\_

School Address \_\_\_\_\_

Phone # \_\_\_\_\_

Registrar's Signature  
  
**X**

**B. MENTAL OR PHYSICALLY DISABLED: ATTENDING PHYSICIAN'S STATEMENT**

PLEASE HAVE YOUR DEPENDENT'S ATTENDING PHYSICIAN COMPLETE AND SIGN THE STATEMENT BELOW, IF YOUR DEPENDENT(S) HAS A MENTAL OR PHYSICAL DISABILITY.

Employee Name \_\_\_\_\_ Employer Name \_\_\_\_\_

|                |              |                            |
|----------------|--------------|----------------------------|
| Dependent Name | Relationship | Employee Social Security # |
|----------------|--------------|----------------------------|

1. Nature and degree of mental and physical disability. (Please furnish full diagnosis):

2. How and when above condition commenced: \_\_\_\_\_ 3. Date individual was last examined: \_\_\_\_\_

4. a) Does the disability restrict the individual's ability to engage in activities of daily living?  Yes  No  
b) Extent of disability:  Full  Partial  Permanent  Temporary

5. Is patient now totally disabled for:  
a) Any occupation  Yes  No  
b) Previous occupation  Yes  No  
c) If Yes to either: when do you think patient will be able to return to work? Approximate Date  Indefinite  Never  
Is the patient a suitable candidate for a rehabilitation program?  Yes  No

6. Please furnish CIGNA HealthCare with any other information which you think would help us make a fair disability determination.

Signature: **X** \_\_\_\_\_ M.D./D.O. Date: \_\_\_\_\_

Address: \_\_\_\_\_