

Group Dental Insurance Program Enrollment Form

CIGNA

Account Number: 3190536



TYPE OR PRINT INFORMATION

1 Name (Last, First, Middle Initial)	Social Security Number	Date of Birth (mm/dd/yy)
	Mailing Address (include ZIP Code)	Work Phone (include area code)
Married <input type="checkbox"/> Yes <input type="checkbox"/> No		Sex <input type="checkbox"/> Male <input type="checkbox"/> Female

2 Type of plan for which you are applying <input type="checkbox"/> Standard <input type="checkbox"/> Premier <input type="checkbox"/> DHMO	Type of enrollment for which you are applying <input type="checkbox"/> Self Only <input type="checkbox"/> Self and Family
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3 In the space below, list all eligible members: wife or husband first; unmarried children under age 22 including (a) legally adopted children, (b) stepchildren, foster children and children who reside with you, (c) any unmarried child over 22 who became disabled before age 22 and is incapable of self-support, (Attach a doctor's certificate for a disabled child.) (d) any unmarried child under age 25 who is a full-time student. Refer to your Benefit Booklet for a complete explanation of who may be covered under your enrollment. **IMPORTANT: Fill in information below only when applying for a family contract, list in order of age, oldest first.**

Names of Family Members (Last name if different, including nickname)	Dependent Address (If different than employee)	Social Security Number	Date of Birth (mm/dd/yyyy)	Sex	Relationship to Employee
SPOUSE					
DOMESTIC PARTNER					
Children (include surname, if different) (Social Security Numbers MUST be included)					

PLEASE RETURN THIS FORM TO HUMAN RESOURCES, MAIL STOP 146.

4 I authorize payroll deduction from my earnings to pay my share of the cost.

Employee Signature _____ Date _____

5 I elect to cancel my present enrollment.

Employee Signature _____ Date _____

(FOR HR USE ONLY)

6 New Hire Open Season Change in marital/family status Separation/Retirement

Effective date of coverage _____ Effective date of coverage _____ Effective date of coverage _____ Effective date of coverage _____

7 I certify that the above named employee is eligible for coverage.

Signature (authorized agency official) _____ Date of receipt _____ PeopleSoft code _____

Remarks _____

PRIVACY ACT STATEMENT

The information you provided on this form is needed to document in your personnel, payroll and/or retirement records file your enrollment in the Group Health Insurance Program. This information will be shared with the health insurance carrier, CIGNA, so that they may (1) identify your enrollment in their plan, (2) verify your and/or your family eligibility for payment of a claim for health benefits services or supplies, and (3) coordinate payment of claims with other carriers with who you might also make a claim for payment of benefits. This information may also be disclosed to other Federal agencies or Congressional offices which have a need to know it in connection with your application for a job, license, grant or other benefit. It may also be shared with national, state, local or other charitable or social security administrative agencies to determine and issue benefits under their programs. In addition, to the extent this information indicates a possible violation of civil or criminal law, it may be shared with an appropriate Federal, state, or local law enforcement agency. Executive Order 9397 dated November 22, 1943 authorizes the use of the Social Security Number to distinguish you and people with similar names. Maintenance of this information is authorized by Section 9 and 10 of the Federal Deposit Insurance Act (12 USC 1819 and 1820), by Section 10 of the Federal Reserve Act (12 USC 244), and by the National Banking Act (12 USC 481). Furnishing your Social Security Number, as well as other data, is voluntary, but failure to do so may result in the inability to obtain health insurance coverage.