

Enrollment/Change Form

CIGNA HealthCare / CoMED HMO

100 Enterprise Drive
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Rockaway, NJ 07866
(201) 361-3444



CIGNA

**Employee: Complete Sections A and B.
Then Sign and Date Section C.**

SECTION A: EMPLOYEE AND DEPENDENT INFORMATION (DO NOT WRITE IN SHADED BOXES)

1. Subscriber Name (Last, First, M.I.)		2. Social Security No.	3. Home Phone	4. Business Phone
5. Address (No.)	(Street)	(City)	(State)	(Zip)
6. County				CN

List All Persons To Be Enrolled Or Affected By A Change					10. You must select a Primary Care Physician. Please enter your preferred selection and an alternate in the event your first is not available.		11. Physician ID No.	12. New Patient	
7. Last Name	First	Middle Initial	8. Birthdate Mo. Day Yr.	9. Sex				Yes	No
01	Subscriber			<input type="checkbox"/> M <input type="checkbox"/> F	First Choice			<input type="checkbox"/>	<input type="checkbox"/>
					Alternate Choice			<input type="checkbox"/>	<input type="checkbox"/>
02	Spouse		Relationship	<input type="checkbox"/> M <input type="checkbox"/> F	First Choice			<input type="checkbox"/>	<input type="checkbox"/>
					Alternate Choice			<input type="checkbox"/>	<input type="checkbox"/>
03	First Dependent		Relationship	<input type="checkbox"/> M <input type="checkbox"/> F	First Choice			<input type="checkbox"/>	<input type="checkbox"/>
					Alternate Choice			<input type="checkbox"/>	<input type="checkbox"/>
04	Second Dependent		Relationship	<input type="checkbox"/> M <input type="checkbox"/> F	First Choice			<input type="checkbox"/>	<input type="checkbox"/>
					Alternate Choice			<input type="checkbox"/>	<input type="checkbox"/>
05	Third Dependent		Relationship	<input type="checkbox"/> M <input type="checkbox"/> F	First Choice			<input type="checkbox"/>	<input type="checkbox"/>
					Alternate Choice			<input type="checkbox"/>	<input type="checkbox"/>
06	Fourth Dependent		Relationship	<input type="checkbox"/> M <input type="checkbox"/> F	First Choice			<input type="checkbox"/>	<input type="checkbox"/>
					Alternate Choice			<input type="checkbox"/>	<input type="checkbox"/>

13. Complete If Enrolling Dependent(s) Age 19 Or Over	Dependent's Name	Full-Time Student <input type="checkbox"/> Yes <input type="checkbox"/> No	Dependent's Name	Full-Time Student <input type="checkbox"/> Yes <input type="checkbox"/> No
14. Complete If Enrolling A Handicapped Dependent Age 19 Or Over In Addition To Above	Handicapped Dependent's First Name (Attach Doctor's Statement)		15. Complete If Enrolling An Adopted Child Or Stepchild	Enter Child's Complete Name And Date Adopted/Marriage Date

SECTION B: OTHER COVERAGE (COB) INFORMATION

16. Spouse's Social Security No.	17. Is Spouse Employed? <input type="checkbox"/> Yes <input type="checkbox"/> No	18. If "Yes", Spouse's Employer Name And Address
19A. Does your spouse have other insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No	19B. If yes, Name, Address And Policy No. Of Insurance Company / HMO Providing Medical Benefits At Spouse's Employer	20. Are You Or Any Of Your Dependents Covered Under Your Spouse's Benefit Plan Or HMO? You <input type="checkbox"/> Yes <input type="checkbox"/> No Dependent(s) <input type="checkbox"/> Yes <input type="checkbox"/> No

Complete the following if you or any dependent is covered by any insurance, HMO, Medicaid or Medicare, other than the plan identified in Box 19B.

22. Name Of Person	23. Type Of Coverage & Policy No.	24. Insurance Company/HMO Name And Address	25. Effective Date	26. Medicare Part A Part B Part A & B <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
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27. Have You Or Your Dependents Ever Been A CIGNA HealthCare Member? <input type="checkbox"/> Yes <input type="checkbox"/> No as: <input type="checkbox"/> Enrollee <input type="checkbox"/> Dependent	If Yes, Under What Name and Social Security No.?	At CIGNA HealthCare Of:
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SECTION C: EMPLOYEE SIGN AND DATE THE FORM

Signature - The information provided above is true and correct to the best of my knowledge, and I accept the provisions on the reverse side of this form. (The subscriber is responsible for the total cost of care received or for drugs purchased which are not authorized by the plan.)

29. Subscriber's Signature	30. Date
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SECTION D: EMPLOYER - COMPLETE THE FOLLOWING (DO NOT WRITE IN SHADED BOXES)

31. Check One: <input type="checkbox"/> Open enrollment <input type="checkbox"/> New Employee <input type="checkbox"/> Change <input type="checkbox"/> Cancellation	32. Date Of Hire	33. Effective Date Or Cancellation Date	34. Group No.	35. Division No.
36. Employer Name	Employer Signature			Contract Type

37. Changes (Check Appropriate Boxes)	<input type="checkbox"/> ID Card Request (List Names In Box 7)	<input type="checkbox"/> Cancel All Dependents
<input type="checkbox"/> Add Dependent	<input type="checkbox"/> Name Change	<input type="checkbox"/> Cancel Named Dependent(s) Only (List Names In Box 7)
<input type="checkbox"/> Address Change	<input type="checkbox"/> Reinstatement of Coverage	<input type="checkbox"/> Marriage <input type="checkbox"/> Divorce
<input type="checkbox"/> Convert To Cobra <input type="checkbox"/> 18 Mos. <input type="checkbox"/> 36 Mos.	<input type="checkbox"/> Cancel All Coverage	<input type="checkbox"/> Age Limit
<input type="checkbox"/> Convert To Non-Group CIGNA HealthCare	<input type="checkbox"/> Left Employ/Laid Off	<input type="checkbox"/> Change In Student Status
<input type="checkbox"/> Physician Change RP Code <input type="checkbox"/>	<input type="checkbox"/> Open Enrollment	<input type="checkbox"/> Other _____
	<input type="checkbox"/> Cost	
	<input type="checkbox"/> Ineligible	
	<input type="checkbox"/> Dissatisfied with HMO	

DS code