Primary Applicant Name_____
Enrollment Form ID_____

Cigna

Cigna Health and Life Insurance Company (Cigna)

Colorado Individual and Family Plan Supplemental Enrollment Form

This form must be completed alongside the Colorado Uniform Individual Application For Major Medical Health Benefit Plans

Section A. Type of Application

New Enrollment Application:
☐ Applicant Only ☐ Applicant and Dependent(s) ☐ Child(ren) Only

Existing Individual Plan Policy Member requesting a change in coverage:
☐ Add Family Member(s) or ☐ Request Plan Change

Subscriber Name:_____ Subscriber ID:_____

Section B. Benefit Plan Options

Select Desired Benefit Plan:

☐ myCigna Health Savings 6100	☐ myCigna Health Savings 3400	☐ myCigna Health Flex 5000	☐ myCigna Health Flex 1250
☐ myCigna Health Flex 5500	☐ myCigna Health Flex 1500	☐ myCigna Copay Assure Silver	☐ myCigna Copay Assure Gold
☐ myCigna Health Flex 5100	☐ myCigna Health Flex 2750	☐ myCigna Health Flex 1900	

Section C. Enrollment Criteria

Applications are accepted during annual open enrollment period or within 60 calendar days of a qualifying event. Please select the applicable enrollment reason.

☐ Annual Open Enrollment

☐ Special Enrollment Period *(Select the qualifying event below)*

- ☐ An individual and any dependents involuntarily lost minimum essential health coverage
- ☐ An individual gained or became a dependent through marriage, civil union, birth, adoption, placement for adoption, or placement in foster care.
- ☐ An individual experienced an error in enrollment
- ☐ An individual adequately demonstrated that the plan or issuer substantially violated a material provision of the contract in which s/he is enrolled
- ☐ An individual became newly eligible or ineligible for advance payments of the premium tax credit or is experiencing a change in eligibility for cost-sharing reductions
- ☐ An individual or enrollee made a permanent move and new coverage is available
- ☐ An individual, who was not previously a citizen, a national, or a lawfully present individual, gains such status
- ☐ An individual released from incarceration
- ☐ An eligible individual and his or her dependent(s) lose employer-sponsored health plan coverage due to voluntary or involuntary termination of employment for reasons other than misconduct, or due to a reduction in work hours
- ☐ An eligible dependent spouse or child loses coverage under an employer-sponsored health plan due to divorce, legal separation or his or her spouse or parent becoming entitled to Medicare or death of his or her spouse or parent
- ☐ An eligible individual loses his or her dependent child status under a parent's employer-sponsored health plan
- ☐ An American Indian/Alaskan Native, as defined by section 4 of the Indian Health Care Improvement Act
- ☐ An individual becomes ineligible for the Children's Basic Health Plan
- ☐ An individual becomes ineligible under the Colorado Medical Assistance Plan

For any Special Enrollment Period reason, provide:
Name(s): _____ and Event Date(s): _____

Section D. Applicant, Spouse and Dependent Information

Applicant's Last Name:	First Name:	M.I.	Social Security Number:

Date of Birth:	Age:	☐ Single ☐ Married	☐ Male ☐ Female	Open Access Plan Primary Care Physician ID Number Optional _____
				Current Patient: ☐ Yes ☐ No

Custodial Parent or Legal Guardian Name (for applicants under the age of 18):	Relationship to Applicant:

Mailing Address – Home Address Required	Billing Address – If different than mailing address	County	Home Phone Number: ( ) _____-_____
Street	P.O. Box / Street		Cell Phone Number: ( ) _____-_____
City State	City State		Work Phone Number: ( ) _____-_____
ZIP Code (Please provide 9-digit ZIP Code)	ZIP Code	Email Address:	

Spouse/Domestic Partner/Civil Union's Last Name		First Name		M.I.	Social Security Number
Date of Birth	Age	☐ Single ☐ Married	☐ Male ☐ Female		Open Access Plan Primary Care Physician ID Number Optional _____ Current Patient: ☐ Yes ☐ No
Dependent children are covered up to age 26. ☐ Check here if you are providing names of additional dependents on an attached separate page.					
Dependent's Last Name		First Name		M.I.	Social Security Number
Date of Birth	Age	☐ Single ☐ Married	☐ Male ☐ Female		Open Access Plan Primary Care Physician ID Number Optional _____ Current Patient: ☐ Yes ☐ No
Dependent's Last Name		First Name		M.I.	Social Security Number
Date of Birth	Age	☐ Single ☐ Married	☐ Male ☐ Female		Open Access Plan Primary Care Physician ID Number Optional _____ Current Patient: ☐ Yes ☐ No

Section E. Payment Method

NOTE: Electronic Funds Transfer - EFT (Automatic draft from a checking or savings account) and Credit Card are the only initial payment methods allowed for online or faxed applications. The accounts will be charged only upon approval of your Application.

Initial Premium Payment Method:

☐ Electronic Funds Transfer (EFT) ☐ Automatic Credit Card Payment ☐ Paper Check

Electronic Funds Transfer – EFT (Automatic draft from a checking or savings account)

☐ Yes, I am requesting EFT both for my initial payment and for ongoing monthly payments (no paper or electronic monthly billing statement will be issued).

☐ Yes, I am requesting EFT for my initial payment. I agree that I am responsible for initiating all subsequent electronic monthly payments. I am requesting monthly electronic bills (eBills) to be sent to my email account as provided in Section D of this application.

Account Number:_____ ☐ Checking ☐ Saving

Routing Number: ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

Name of Bank:_____ Name(s) on Account:_____

I authorize the Company (Cigna) to make monthly withdrawals, in the amount of my monthly premium, from my bank account as identified on this form and authorize the banking facility (Bank) to charge such withdrawals to my account. This authority will remain in effect until the Company receives written notice from me that the authority is terminated. Such termination will be effective with respect to the next premium due following 21 days after the written notice is received by the Company. I understand that if for any reason, a withdrawal is not honored by the Bank (including, but not limited to, insufficient funds or my direction to the Bank not to honor the withdrawal) my health care contract premium will be unpaid, and failure to pay my health care contract premium may result in termination for my health care contract, that I may be charged an administration fee in addition to my healthcare premium, and that this authorization will remain in place until cancelled and that any due or past due premiums may be withdrawn under this authorization. I understand and agree that termination of this authorization does not relieve me of responsibility for charges incurred under my health care contract. I agree to indemnify and hold harmless the Company and its affiliates and employees for any claims arising out of transfers or deductions from my account in accordance with this authorization.

Credit Card (Available for initial payment only)	☐ VISA ☐ MASTERCARD
Cardholder's Name – exactly as it appears on the card:	
Account Number: ☐☐☐☐-☐☐☐☐-☐☐☐☐-☐☐☐☐ Account Holder's ZIP Code: ___ ___ ___ ___ ___ – ___ ___ ___ ___	Card Expiration Date:

For Paper Application: ***Please check here:*** ☐ Paper check is attached or ☐ Credit card information provided.

Ongoing Payment Options if paying by paper check or credit card for initial payment (please select one option only)

☐ **Monthly Paper Bill:** Yes, I am submitting a paper check (or have selected the credit card option) for my initial payment. I will submit a check for my ongoing monthly payments.

☐ **EFT Draft:** Yes, I am submitting a paper check for my initial payment (or have selected the credit card option) and I am requesting recurring automatic EFT drafts for ongoing monthly payments. (No paper or electronic monthly or quarterly billing statements will be issued.) *Please complete the EFT section above.*

☐ **Monthly Electronic Bill (eBill):** Yes, I am submitting a paper check (or have selected the credit card option) for my initial payment and agree that I am responsible for initiating all subsequent electronic monthly payments. I am requesting monthly electronic bills (eBills) to be sent to my email account provided in Section D of this application.

For Online electronic submitted Application:
Ongoing Payment Options if Credit Card Option was selected for initial payment (please select one option only).

☐ **EFT Draft:** Yes, I agree to recurring automatic EFT drafts for my ongoing monthly payments. (No paper or electronic monthly billing statement will be issued.) Please complete the EFT section above.

☐ **Monthly Electronic Bill (eBill):** Yes, I agree that I am responsible for initiating my ongoing electronic monthly payments. I am requesting monthly electronic bills (eBills) to be sent to my email account as provided in Section D of this application.

Section F. Contact Information

Please return the application enrollment form to the broker or submit to the address listed below:

Cigna Individual and Family Plans
P.O. Box 30362
Tampa, FL 33630-3362
FAX # 877.484.5927
www.Cigna.com

All applicants 18 years and older must sign and date application. Applicants under the age of 18 require custodial parent or legal guardian signature acknowledging their understanding of and agreement to the conditions listed above.

Applicant Signature:	Today's Date: (MM/DD/YYYY)	Spouse/Domestic Partner/Civil Union's Signature:	Today's Date: (MM/DD/YYYY)
Applicant's Dependent Age 18 or Older:	Today's Date: (MM/DD/YYYY)	Applicant's Dependent Age 18 or Older:	Today's Date: (MM/DD/YYYY)
Custodial Parent or Legal Guardian Signature (for applicants under the age of 18):			Today's Date: (MM/DD/YYYY)

"Cigna" and the "Tree of Life" logo are registered service marks of Cigna Intellectual Property, Inc., licensed for use by Cigna Corporation and its operating subsidiaries. All products and services are provided by or through such operating subsidiaries, including Cigna Health and Life Insurance Company and Cigna Dental Health, Inc., and not by Cigna Corporation.

Division of Insurance

COLORADO UNIFORM INDIVIDUAL APPLICATION FOR MAJOR MEDICAL HEALTH BENEFIT PLANS

This form is designed for an individual's initial application for coverage. Please contact your carrier with questions regarding this form.

Federal financial assistance may be available for coverage purchased through Connect for Health Colorado. If purchasing coverage through Connect for Health Colorado, you will need to provide additional information for determination of eligibility for federal financial assistance. Further information may be found at www.connectforhealthco.com.

COVERAGE INFORMATION

Application Type:	☐ New Coverage ☐ Change/Modification to Existing Coverage ☐ Open Enrollment ☐ Special Enrollment*
Requested Effective Date:	_____/_____/_____ (MM/DD/YYYY)

* Proof of eligibility for special enrollment will be required – information on eligibility for special enrollment periods is available at: www.dora.colorado.gov/DOI/HealthApp

PRIMARY APPLICANT/INSURED INFORMATION

Instructions: Please type or print using black or blue ink. Please fill out the entire application for each person for whom coverage is being sought. If a person is currently enrolled in Medicare, this application should not be completed for that enrolled individual. If additional pages are needed to fully complete this application please attach, sign, and date each page.

First Name:		Middle Initial:		Last Name:	
Social Security #:		Date of Birth:	/ /	Current Age:	Sex: ☐ M F ☐
Physical Address:				City:	
County:		State:		Zip:	
Mailing Address (If different):				City:	
County:		State:		Zip:	
Home Phone:		Alternate Phone:		Email:	

Are you (check one): ☐ Single ☐ Married ☐ Common Law* ☐ Civil Union* ☐ Legally Separated ☐ Divorced ☐ Under 21

Are you or is anyone in your family American Indian or Alaskan Native? ☐ Yes ☐ No

* A common law, civil union, or designated beneficiary certification may be required by the carrier

Employer Name and Address:		Work Phone:	

ADDITIONAL APPLICANTS

Complete ONLY if your spouse/partner, and/or child(ren) under the age of 26(older if medically disabled) are applying for coverage. If a dependent child is applying an as individual rather than as part of a family list the child as the primary applicant. If there is not enough space provided, please attach additional family information. **Please sign and date the additional sheet.**

*Social Security Numbers (or document numbers for any legal immigrants) are needed for anyone applying for health insurance, missing numbers will be requested after enrollment

Name (First, MI, Last)	Sex	Social Security #	Relationship	Disabled	Birth Date (MM/DD/YY)	Employer Name and Position
	☐ M ☐ F		SPOUSE/PARTNER			
	☐ M ☐ F		☐ CHILD ☐ STEPCHILD	☐ Yes ☐ No		
	☐ M ☐ F		☐ CHILD ☐ STEPCHILD	☐ Yes ☐ No		
	☐ M ☐ F		☐ CHILD ☐ STEPCHILD	☐ Yes ☐ No		

Do(es) the child(ren) named within the application live with you at the same physical address shown above? ☐ Yes ☐ No (if no, complete below)

Child(ren)'s Name:			Mailing Address (If different):				
City:		County:		State:		Zip:	
Home Phone:		Alternate Phone:		Email:			

Primary Applicant Name:

Name of the Legal Guardian or Parent responsible for carrying health insurance for the child:							
If the primary applicant is under the age of 21 if different from above, provide the name and mailing address of the legal guardian or custodial parent:							
Legal Guardian or Custodial Parent's Name:		Mailing Address (If different):					
City:		County:		State:		Zip:	
Home Phone:		Alternate Phone:		Email:			

TOBACCO USE

Please answer the following questions to the best of your knowledge. 45 CFR 147.102(a)(1)(iv) "For purposes of this section, tobacco use means use of tobacco on average four or more times per week within no longer than the past 6 months. This includes all tobacco products, except that tobacco use does not include religious or ceremonial use of tobacco. Further, tobacco use must be defined in terms of when a tobacco product was last used."

Has anyone named in this application used tobacco or smokeless tobacco during the past 6 months? If yes, provide the information requested below.

Name of Person	Used Tobacco Products	If Yes, check all that apply	Duration	Frequency
	☐ Yes ☐ No	☐ Cigarettes ☐ Chewing Tobacco ☐ Pipe/Cigars		
	☐ Yes ☐ No	☐ Cigarettes ☐ Chewing Tobacco ☐ Pipe/Cigars		
	☐ Yes ☐ No	☐ Cigarettes ☐ Chewing Tobacco ☐ Pipe/Cigars		
	☐ Yes ☐ No	☐ Cigarettes ☐ Chewing Tobacco ☐ Pipe/Cigars		

MEDICARE/MEDICAID INFORMATION

Is any applicant enrolled in Medicare? ☐ Yes ☐ No

Name of person covered by Medicare: _____. For this applicant, please stop here, this insurance may duplicate existing Medicare coverage.

Is any applicant enrolled in Medicaid, CHIP+, or other governmental health program? ☐ Yes ☐ No

Name of person covered by Medicaid or other governmental health program: _____. For this applicant, please be aware that obtaining individual health insurance may affect this individual's Medicaid status.

CURRENT MEDICAL COVERAGE

Do you, your spouse/partner, or your dependent child(ren) listed in this application currently have health insurance? ☐ Yes ☐ No

(Dental Coverage in next Section)

Name	Carrier Name	Effective Date of Coverage (MM/DD/YY)	Termination Date of Coverage (MM/DD/YY)	Coverage Type

If any applicant has current health coverage, will that applicant cancel current coverage if this applicant is accepted? ☐ Yes ☐ No

Type of Coverage Key: **G** = Group Comprehensive Major Medical; **I** = Individual Comprehensive Major Medical; **MS** = Medicare Supplement; **H** = Hospital Coverage Only; **V** = Vision Coverage Only **O**=Other, please explain:_____

Primary Applicant Name:

CERTIFICATION OF DENTAL INSURANCE COVERAGE (Certification of dental insurance coverage is not required when purchasing coverage through Connect for Health Colorado)	
Pediatric dental coverage is a required essential health benefit. The plan you select may not include pediatric dental coverage. Do you have pediatric dental coverage under another plan?	☐ Yes ☐ No Note: you may be required provide proof that you have obtained coverage before this policy will be approved

TERMS AND CONDITIONS

I acknowledge that I have read all sections of this Application, and I certify on behalf of my eligible family dependents and myself that the answers contained in this Application are complete and accurate to the best of my knowledge.

I understand that my answers, together with any supplements or additional pages, are the basis for the certificate or policy that is issued. I agree that no insurance will be effective until the date specified by the carrier on the certificate or policy.

I understand that my signature constitutes an attestation that I have obtained the required pediatric dental coverage under a separate policy, and may be required to provide proof of this pediatric dental policy prior to this policy being issued and approved. (Certification of dental insurance coverage is not required when purchasing coverage through Connect for Health Colorado)

I understand that any intentional misrepresentation relied upon by the carrier may be used to deny a claim. I further understand that this contract can be voided if, within the first 24 months from the date of the policy or certificate, it is determined that I or a family member made an intentional misrepresentation in this application.

It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance carrier for the purpose of defrauding or attempting to defraud the carrier. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance carrier or agent of an insurance carrier who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

I understand that I may request a copy of this Application. I agree that a photographic copy of this Application shall be as valid as the original. A legible facsimile signature shall have the same force and effectiveness as the original. This document, or the information contained herein, will become a part of the contract when coverage is approved and issued.

I would like to receive all policy notices, premium notices, and other notices relating to this policy through the supplied email address above. ☐Yes ☐No

I understand I can change this designation at a later date by contacting my carrier directly, and understand it is my responsibility to notify my carrier of any changes to my email address.

Signature of Primary Applicant/Parent or Legal Guardian for Child-Only Plans	Date Signed:

Complete this section if someone assisted you in the completion of this Application	
The following person assisted me in completing the Application:	Please explain the assistant's relationship to you and your family:

Primary Applicant Name:

AGENT/PRODUCER INFORMATION	
This section is to be completed by Agent or Producer.	
Agent / Agency of Record: (for commissions and correspondence)	Writing Agent / Producer: Lori Fennessey
Name (print): Lori Fennessey	Name (print): Lori Fennessey
Agent ID # (NPR): 405972	Agent ID #(NPR): 405972
Agent replacement questions: Will this policy replace any existing accident and sickness insurance policy(s)? ☐Yes ☐No As the Writing Agent/Producer, I acknowledge that I am responsible to personally interact with the primary applicant submitting this application in order to fully and accurately represent the terms and conditions of the plans and services of the offering or insuring entity, or one of its subsidiaries. These provisions are available to me and the primary applicant in the benefits summary document or other plan literature.	
Writing Agent Signature	**Date**

DISCLOSURES

This document is a publication of the Colorado Division of Insurance. If you have questions about the content of this document please contact our offices at 303-894-7499 or visit our website at http://www.dora.colorado.gov/insurance. For questions regarding coverage or enrollment please see your carrier.

This section may be used to provide additional information that was required in the sections above and did not fit in the space provided.

Signature of Primary Applicant: _____ **Date Signed:** _____