Form Information

# Texas Employee Enrollment/Change of Coverage Form

(for groups with 2-50 employees)

| Employee Social Security Number: |
|---|
| Group Number: *(Existing CIGNA member)* |

**Instructions:** You, the employee, must complete this enrollment form in full to avoid in a delay in processing. You are solely responsible for its accuracy and completeness. **If waiving coverage, please complete Sections 1 and 4 only.**

## SECTION 1 – Employee/Employer Information

| Employee Name: | Employer Name / Location: | | | Date of Hire: |
|---|---|---|---|---|
| Employee Street Address, City, State and ZIP Code: | Employee Mailing Address, City, State and ZIP Code: | | | Home Phone No.<br>Work Phone No: |
| Employment Status:<br>☐ Full-Time ☐ Temporary ☐ Other<br>☐ Part-Time ☐ Seasonal _____ | # Hours Worked Per Week: | # Enrolling (including self): | Marital Status:<br>☐ Married ☐ Single | Proposed Effective Date: |

| Reason for Application: | | COBRA or State Continuation Original Qualifying Event Date: |
|---|---|---|
| ☐ New Group Enrollment | ☐ Rehire | |
| ☐ New Hire | ☐ Change of Address | Reason: |
| ☐ Late Enrollee | ☐ Name Change Only | |
| ☐ Change of Coverage (existing insured only) | ☐ Add Dependents (Spouse/Dependent Child) | Length of Continuation: |
| | ☐ COBRA or State Cont Enrollment | ☐ 18 months ☐ 36 months ☐ Other ____ months |

## SECTION 2 – Plan Selection – Please indicate the plan and option your employer offers in which you are enrolling.

Note: You can only enroll in a plan your employer has selected to offer your group.

| Open Access Plans | Health Savings Plans | PPO Plans |
|---|---|---|
| ☐ OAP 500 | ☐ HSP 1500 | ☐ PPO Plan 1 |
| ☐ OAP 1000 | ☐ HSP 2500 | ☐ PPO Plan 2 |
| ☐ OAP 1500 | ☐ HSP 5000 | |
| ☐ OAP 2000 | | |

## SECTION 3 – Complete for All Individuals to Be Covered (dependent children are covered to age 25)

| Last Name | First Name | Sex M/F | Social Security Number | Date of Birth mm/dd/yyyy | Height; Ft./In. | Weight Lbs. | Disabled | Name of Primary Care Physician (PCP) Optional for OAP | Current Patient? |
|---|---|---|---|---|---|---|---|---|---|
| **Employee:** | | | | | | | ☐ Yes | | ☐ Yes |
| Spouse: | | | | | | | ☐ Yes | | ☐ Yes |
| Child: | | | | | | | ☐ Yes | | ☐ Yes |
| Child: | | | | | | | ☐ Yes | | ☐ Yes |
| Child: | | | | | | | ☐ Yes | | ☐ Yes |

## SECTION 4 – Waiver of Coverage – Only complete if waiving coverage for any reason.

**I understand that I am eligible for the coverage being offered. However, I and/or the dependents listed below voluntarily waive the coverage. If coverage is waived, I am also stating the reasons why I/we are waiving coverage. (Please list names and indicate reasons below.)**

| | | |
|---|---|---|
| ☐ Employee | ☐ Med | **Reason for waiving coverage:** |
| ☐ Spouse | ☐ Med | ☐ Covered by Spouse's group coverage<br>Provide Carrier Name and proof of other coverage _____ |
| ☐ Child(ren): | ☐ Med | ☐ Enrolled in other Non-Group coverage:<br>☐ Medicare ☐ Retiree ☐ Military ☐ COBRA ☐ State Continuation<br>☐ Individual Private Insurance ☐ Other, list other Insurance Company Name _____<br>☐ Other reason for waiving coverage _____ |

By waiving this coverage, I acknowledge that myself and/or dependent(s) may have to wait to enroll until the plan's next renewal date. Pre-Existing waiting periods and limitations may apply at the time of a future enrollment.

| Sign here **only** if you are waiving coverage for yourself and/or dependents: | Date: |
|---|---|
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**SECTION 5 – Medical Questions**

Health Questionnaire for all individuals enrolling (this includes employees, dependents and individuals on Cobra or State Continuation).

**For any "Yes" answers in this section, details must be provided in Section (6) in order to process application.**

**Has any individual listed on this enrollment form in the last 5 years seen a healthcare provider(s), received treatment, been recommended treatment, been hospitalized, had diagnostic tests, taken or been recommended to take prescription medications, for any of the following conditions:**

| | | |
|---|---|---|
| 5.1. | **Eyes, Ears, Nose, Throat:** Chronic Ear Infections, Cleft Lip/Palate, Chronic Sinusitis, Acoustic Neuroma, Glaucoma, Cataracts, Retinopathy or any other condition not listed here. | ☐ Yes ☐ No |
| 5.2. | **Endocrine/Hormonal:** Addison's, Adrenal Disorders, Diabetes, Gaucher's, Thyroid Disorders, Cushing's, Pituitary Disorders, Menopause, or any other condition not listed here. | ☐ Yes ☐ No |
| 5.3. | **Heart/Circulatory:** Anemia, Aneurysm, Congestive Heart Failure, Heart Attack, Coronary Artery Disease, Hemophilia, High Blood Pressure, High Cholesterol/Lipids, Irregular Heartbeat, Pace Maker, Stroke, Valve Conditions, Heart Murmur, or any other condition not listed here. | ☐ Yes ☐ No |
| 5.4. | **Gastro-Intestinal/Liver:** Crohn's Disease, Colon Disorder, Cirrhosis of the Liver, Hepatitis, Gallbladder, Hernia, Esophagitis, Gastric Reflux, Ulcer, Colitis, Irritable Bowel, Gastric Bypass, Pancreatitis Chronic Diahrrea, Obesity, or any other condition not listed here. | ☐ Yes ☐ No |
| 5.5. | **Genito-Urinary:** Kidney Stones, Bladder Disorder, Urinary Tract Infection, Kidney Disorder, Renal Failure, Neurogenic Bladder, Polycystic Kidney, Prostate Disorder, Erectile Dysfunction, Cystocele/Rectocele, Uterine Prolapse, Uterine Fibroid, Polycystic Ovaries, Endometriosis, or any other condition not listed here. | ☐ Yes ☐ No |
| 5.6. | **HIV/AIDS/ARC:** Have you or any of your eligible dependents received treatment or been diagnosed by a Physician or Healthcare Provider with any of the following conditions: Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC) or HIV? | ☐ Yes ☐ No |
| 5.7. | **Lungs/Respiratory:** Asthma/Allergies, Bronchitis, Pneumonia, COPD, Emphysema, Sleep Apnea, Tuberculosis, Pneumo-thorax, Cystic Fibrosis or any other condition not listed here. | ☐ Yes ☐ No |
| 5.8. | **Neurologic/Mental:** ADD/Hyperactivity, Alzheimer's, Anxiety, Depression, Bipolar, Drug/Alcohol Abuse, Epilepsy/Seizures, Chronic Fatigue, Mental Retardation, Multiple Sclerosis, Cerebral Palsy, Polio, Paralysis, Hemiplegia, Spinal or Brain Trauma, Parkinson's Disease or any other condition not listed here. | ☐ Yes ☐ No |
| 5.9. | **Muscular/Skeletal:** Arthritis, Joint/Bone Disorders, Fractures, Disc Disorders, Lupus, Muscular Dystrophy, Neck/Back Disorders, Fibromyalgia, or any other condition not listed here. | ☐ Yes ☐ No |
| 5.10. | **Miscellaneous:** Acne, Psoriasis, Congenital Birth Defects, Burns, Eating Disorders, Sexually Transmitted Diseases. | ☐ Yes ☐ No |
| 5.11. | Has anyone listed on this enrollment form received or been recommended to receive Fertility or Infertility treatment or any method of Assisted Reproductive Therapy? | ☐ Yes ☐ No |
| 5.12. | Is anyone listed on this enrollment form currently on a list to receive or donate an organ? | ☐ Yes ☐ No |
| 5.13. a. | Is any female to be covered currently pregnant? If "yes," what is the due date?_____ | ☐ Yes ☐ No |
| b. | Have there been any complications thus far? | ☐ Yes ☐ No |
| c. | Is a normal delivery expected? | ☐ Yes ☐ No |
| d. | Are multiple births expected? | ☐ Yes ☐ No |
| 5.14. | If you are a male listed on this enrollment form, are you expecting a child with anyone, even if the mother is not listed on this enrollment form? If yes, provide due date:_____. | ☐ Yes ☐ No |
| 5.15. | Does anyone listed on this enrollment form use any form of tobacco products?<br>If yes: Name: _____ Quantity: _____ If quit: Date: _____<br>If yes: Name: _____ Quantity: _____ If quit: Date: _____ | ☐ Yes ☐ No |
| 5.16. | Has anyone listed on this enrollment form received Workers' Compensation benefits within the last 12 months, if so provide details? | ☐ Yes ☐ No |
| 5.17. | Has anyone listed on this enrollment form received treatment or been recommended treatment for any other condition not mentioned on this enrollment form? | ☐ Yes ☐ No |
| 5.18. | Has anyone listed on this enrollment form been advised to see a specialist, or have diagnostic testing or surgery which has not yet been done? | ☐ Yes ☐ No |
| 5.19. | Has anyone on this enrollment form been diagnosed with any type of cancer or tumor within the last 10 years? | ☐ Yes ☐ No |

 

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**SECTION 6 – Health History Details –** For all "Yes" answers provided in Section 5, provide full details below. If additional room is needed to provide details, attach a separate sheet of paper. Sign and date the additional sheet. Note: Incomplete answers may affect the final underwriting decision.

| Name of Enrollee | Question Number | Name of Condition | Onset Date | Type of Treatment Received or Recommended | Treatment End Date | Name of Medication Prescribed | Dosage | Medication End Date or Ongoing |
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| **For any instance of High Blood Pressure or High Cholesterol, please provide latest lab values and/or Blood Pressure readings.** | | | | | |
|---|---|---|---|---|---|
| Name of Enrollee: | BP Reading: /<br>Last date taken: | Cholesterol Levels<br>Total: _____<br>Triglycerides: _____<br>HDL: _____<br>LDL: _____ | Name of Enrollee: | BP Reading: /<br>Last date taken: | Cholesterol Levels<br>Total: _____<br>Triglycerides: _____<br>HDL: _____<br>LDL: _____ |

**SECTION 7 – Other Coverage –** Non completion of this section and failure to provide Proof of Prior Coverage may subject you and/or an enrolling family member to Pre-Existing waiting periods and limitations.

Does anyone enrolling on this form have current or prior coverage? ☐ Yes ☐ No If answered "Yes", complete section below and provide Proof of Prior Coverage.

| Name: | Prior or Current Insurance Company Name: | Start Date: | End Date: | Currently On Medicare: ☐ Yes ☐ No<br>If under age 65 and answered yes, please indicate reason. | List which part of Medicare (Parts A, B, D): |
|---|---|---|---|---|---|
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**SECTION 8 – Dependent Information**

☐ Does any dependent listed in Section 3 live at another address? ☐ Yes ☐ No

If answered "Yes," who and at what address: _____ _____.

☐ If any dependent's last name differs from yours, explain the circumstances: _____.



Click Here to Print Clear Fields

## SECTION 9 – Authorization

- **Authorization to release medical records.** I authorize CIGNA to request my and/or my dependents' (those who are applying for coverage under this enrollment form) medical records, any prescribed medication history, and any other medical or pharmaceutical information to process my enrollment form. I authorize any health care provider, including hospitals, physicians, clinics, labs, pharmacies, pharmacy benefit managers or any other healthcare organizations or healthcare professionals that provided treatment or any other service to me and/or any of my dependents applying for coverage under this enrollment form to disclose to CIGNA the information required by CIGNA and described above. This authorization becomes effective immediately and shall remain in effect as long as necessary to permit evaluation of this application. I further agree that I or my dependents will sign any additional authorization form that may be required for release of such information.
- **Acknowledgment of key terms.** In completing this Application, I agree to the following for myself and all eligible dependents:

1. That any hospital, physician or other provider may furnish CIGNA medical information that may be required to conduct a utilization review program of health services, and to coordinate benefits and/or reimbursements with other health or insurance programs.
2. That all information furnished by me is true and complete to the best of my knowledge, and that I shall update the application with changes occurring between the date of this application and the first date of coverage, including new or changed medical conditions.
3. That any person who knowingly and with intent to defraud CIGNA or any other person files application for insurance or statement of claim containing any material false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act and may be subject to civil and criminal penalties.
4. That my employer's application will determine coverage and that I will not receive coverage until both this application and the employer's application have been accepted and approved by CIGNA.
5. That should I and my dependents be issued coverage, any dispute or claim shall be resolved according the grievance procedures contained in the Certificate of Coverage issued by CIGNA to enrollees.
6. That should I and my dependents be issued coverage, there may be a waiting period before pre-existing health conditions of me or my dependents are covered, as further explained in the Certificate of Coverage issued by CIGNA to enrollees.
7. That should I or my dependents be issued coverage and CIGNA provides health services that are the primary responsibility of Medicare, workers' compensation coverage, automobile medical payment coverage, or other payments source CIGNA may be authorized by law to pursue, we shall inform CIGNA of the other source of payment and execute such documents and provide such assistance as may be necessary to enable CIGNA to recover the value of services provided, arranged or covered.
8. That I am entitled upon request to a copy of this application, including the authorizations and acknowledgements made by me herein.

| Employee Signature: | Today's Date: |
|---|---|
| | |

- Please keep a copy of this application for your records.
- NOTE: If there are any modifications to the statements and responses provided in this application (i.e. crossed out, white-out, erased information), the applicant must attest to the modifications by providing a complete signature in the margin near the modification