

# CIGNA Dental Enrollment Form

Employer: Complete Section A

Employee: Complete Sections B, C & D

CIGNA Dental Health, Inc.  
Insured dental plans underwritten by  
Connecticut General Life Insurance Company  
P.O. Box 22170  
Tempe, AZ 85285-2170



CIGNA Dental

Please print and thank you for providing this information

<b>A</b>	<input type="checkbox"/> OPEN ENROLL. <input type="checkbox"/> CHANGE <input type="checkbox"/> NEW ENROLL. <input type="checkbox"/> REINSTATE	EFFECTIVE DATE OF ADD/CHANGE/ CANCELLATION (MM/DD/CCYY)	EMPLOYER NAME <b>Hempstead Public Schools</b>		EMPLOYER ADDRESS <b>185 Peninsula Blvd Hempstead, NY 11550</b>		
	CIGNA ACCOUNT NO.	DIVISION/BRANCH/LOCATION/CLASS	DATE OF HIRE (MM/DD/CCYY)	NETWORK ID	BRANCH CODE	CDH GROUP NO.	DENTAL BENEFIT OPTION
TYPE OF CHANGE: <input type="checkbox"/> Add Dependent(s) *   Date: _____ <input type="checkbox"/> Address Change <input type="checkbox"/> Cancel Employee   Last Date of Coverage: _____ <input type="checkbox"/> Transfer to COBRA <input type="checkbox"/> Cancel Dependent(s) *   Last Date of Coverage: _____ <input type="checkbox"/> 18 mos. <input type="checkbox"/> 29 mos. <input type="checkbox"/> 36 mos. Reason for Cancellation: <input type="checkbox"/> Leave employment <input type="checkbox"/> Other _____ <input type="checkbox"/> Transfer out of CIGNA Dental Care area <input type="checkbox"/> Transfer to another plan							
* List Names in Section C							

<b>B</b>	EMPLOYEE NAME (Last) _____ (First) _____ (M.I.) _____			SOCIAL SECURITY NO. _____	
	EMPLOYEE DATE OF BIRTH (MM/DD/CCYY)	HOME PHONE ( ) ( ) ( )	WORK PHONE ( ) ( ) ( )	HOME E-MAIL ADDRESS _____	EMPLOYEE IDENTIFICATION NUMBER _____
	ADDRESS (Street) _____ (City) _____ (State) _____ (Zip Code) _____				
	WHAT IS YOUR PRIMARY LANGUAGE? (optional) _____		DO YOU HAVE A DISABILITY AFFECTING YOUR ABILITY TO COMMUNICATE OR READ? (optional) <input type="checkbox"/> Yes <input type="checkbox"/> No		SELECT PLAN: <input type="checkbox"/> CIGNA Dental Care <input type="checkbox"/> CIGNA Dental EPO <input type="checkbox"/> CIGNA Dental PPO <input type="checkbox"/> CIGNA Traditional

I WOULD LIKE COVERAGE FOR ME AND MY DEPENDENTS. (Specify last name if different from yours)			DEPENDENT SOCIAL SECURITY NO.	DATE OF BIRTH MM DD CCYY	GENDER	FULL-TIME STUDENT? Yes No	DENTAL OFFICE SELECTION (for CIGNA Dental Care only)	START DATE OF CONTINUOUS DENTAL COVERAGE (for CIGNA Dental PPO only) (Month, Day, Year)	(check one)
Employee	Last Name	First Name	M.I.		<input type="checkbox"/> M <input type="checkbox"/> F		1st Choice - 2nd Choice -		<input type="checkbox"/> Add <input type="checkbox"/> Cancel
Spouse					<input type="checkbox"/> M <input type="checkbox"/> F		1st Choice - 2nd Choice -		<input type="checkbox"/> Add <input type="checkbox"/> Cancel
Dependent			Relationship		<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> <input type="checkbox"/>	1st Choice - 2nd Choice -		<input type="checkbox"/> Add <input type="checkbox"/> Cancel
Dependent			Relationship		<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> <input type="checkbox"/>	1st Choice - 2nd Choice -		<input type="checkbox"/> Add <input type="checkbox"/> Cancel
Dependent			Relationship		<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> <input type="checkbox"/>	1st Choice - 2nd Choice -		<input type="checkbox"/> Add <input type="checkbox"/> Cancel

Please submit proof of student or handicapped status for coverage dependents.  
The original effective date must be completed for each member in order for continuous coverage credit to be applied toward waiting period.

<b>D</b>	<b>SIGNATURE</b> - 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 which I have read and understand. EMPLOYEE'S SIGNATURE / DATE _____
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CIGNA Dental refers to the following operating subsidiaries of CIGNA Corporation: Connecticut General Life Insurance Company and CIGNA Dental Health, Inc., and its operating subsidiaries and affiliates. The CIGNA Dental Care plan is provided by CIGNA Dental Health Plan of Arizona, Inc., CIGNA Dental Health of California, Inc., CIGNA Dental Care of Colorado, Inc., CIGNA HealthCare of Connecticut, Inc., CIGNA Dental Health of Delaware, Inc., CIGNA Dental Health of Florida, Inc., a Prepaid Limited Health Services Organization licensed under Chapter 636, Florida Statutes, CIGNA Dental Health of Kansas, Inc. (Kansas and Nebraska), CIGNA Dental Health of Kentucky, Inc., CIGNA Dental Health of Illinois, Inc., CIGNA Dental Health of Maryland, Inc., CIGNA Dental Health of Missouri, Inc., CIGNA Dental Health of New Jersey, Inc., CIGNA Dental Health of North Carolina, Inc., CIGNA Dental Health of Ohio, Inc., CIGNA Dental Health of Pennsylvania, Inc., CIGNA Dental Health of Texas, Inc., and CIGNA Dental Health of Virginia, Inc. In other states, the CIGNA Dental Care plan is underwritten by Connecticut General Life Insurance Company and administered by CIGNA Dental Health, Inc. The CIGNA Dental PPO and CIGNA Dental EPO plans are underwritten or administered by Connecticut General Life Insurance Company with network management services provided by CIGNA Dental Health, Inc., and certain of its operating subsidiaries. The CIGNA Traditional plan is underwritten or administered by Connecticut General Life Insurance Company.

NOTE: Not all products are available for all clients or all states. Check your enrollment materials carefully to see what is offered for your group.