



**CIGNA HealthCare
of North Carolina, Inc.**

CIGNA HealthCare/Employer Services
P.O. Box 2010
Concord, NH 03302
(800) 849-9000 / (800) 227-4918

CHECK BOX:

- ENROLLMENT FORM - New Members: Complete all items in Sections B, C, D.
- CHANGE FORM - Current Members: Check all items you wish to change under Section A. Complete Section B. Update other appropriate sections with changes.
- TRANSFER - From one location to another.

(NOTE: DO NOT FILL IN SHADED AREAS)

**MUST BE COMPLETED
BY BENEFIT REP ONLY**

Benefit Rep: _____
 Effective Date: _____
 Group #: _____
 Sub-Group #: _____

Account Change
 Effective Date: _____

HMO POS

**ENROLLMENT APPLICATION
AND CHANGE FORM**

A. IF MAKING A CHANGE FROM PREVIOUS ENROLLMENT, COMPLETE:

CHECK ALL THAT APPLY: <input type="checkbox"/> Name Change <input type="checkbox"/> Address Change <input type="checkbox"/> Telephone Change <input type="checkbox"/> Primary Care Physician Change <input type="checkbox"/> OB/GYN Physician <input type="checkbox"/> Date of Birth Correction <input type="checkbox"/> ID Card Request	ADD DEPENDENT(S): <input type="checkbox"/> Marriage <input type="checkbox"/> Newborn <input type="checkbox"/> Adoption <input type="checkbox"/> Loss of Coverage/Documentation Must Be Attached <input type="checkbox"/> Legal Guardian for Dependents/Documentation Must Be Attached <input type="checkbox"/> Other _____	CANCEL DEPENDENT(S): <input type="checkbox"/> Marriage <input type="checkbox"/> Divorce/Separation <input type="checkbox"/> Age Limit <input type="checkbox"/> Death <input type="checkbox"/> Other _____	CANCEL ENTIRE POLICY: <input type="checkbox"/> Terminated Employment <input type="checkbox"/> Moved Out of Service Area <input type="checkbox"/> COBRA Termination <input type="checkbox"/> Deceased <input type="checkbox"/> Non-Payment of Premium <input type="checkbox"/> Open Enrollment - Changed <input type="checkbox"/> Other _____	COBRA: <input type="checkbox"/> Elect COBRA _____ Effective Date COBRA QUALIFYING EVENT: <input type="checkbox"/> Death <input type="checkbox"/> Termination of Employment <input type="checkbox"/> Reduction in Hours <input type="checkbox"/> Divorce/Separation <input type="checkbox"/> Medicare Eligibility <input type="checkbox"/> Social Security Disability Determination <input type="checkbox"/> Overaged Dependent Now Ineligible	REINSTATEMENT: <input type="checkbox"/> Return from Layoff <input type="checkbox"/> Return from Leave <input type="checkbox"/> Retire <input type="checkbox"/> Disenrollment Error <input type="checkbox"/> Other _____
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B. EMPLOYEE INFORMATION:

Last Name	First Name	Middle Initial	Social Security No. - -	Marital Status
Address			City	State
			Zip	Home Phone () -
Hire Date	Employer Name, Address			Work Phone () -

C. FAMILY INFORMATION:

**You must select and indicate the full name of a Primary Care Physician, Individual Physician Name not Practice Name, from the Participating Physicians and Providers Directory provided in your enrollment package for each person listed below. Your application will not be processed and your coverage will not be effective until you have indicated your selections.*

Name (Last, First, Middle Initial)	Relationship	Social Security Number	Birth Date	Sex	Primary Care Physician (Full Name) *SEE ABOVE NOTE	Current Patient Y/N	OB/GYN Physician (Full Name) *SEE ABOVE NOTE	Current Patient Y/N
Employee								
Spouse								
Child								
Child								
Child								
Child								
Child								
Child								

*Female Members may also select an OB/GYN Physician at the time of enrollment or later by contacting the Plan's Member Relations Department.

Have you or any Family Dependents been a previous CIGNA HealthCare of North Carolina member? YES NO Dates and ID# _____

Are any dependents covered under another health plan due to divorce/separation/court order? YES NO

D. OTHER INSURANCE INFORMATION INCLUDING MEDICARE BENEFITS:

Name, Address & Phone Number of Other Insurance Company () -	Policyholder Name and Date of Birth
Policyholder's Employer, Address & Phone () -	Policyholder Social Security # - -
Policy Number / Effective Date of Coverage	Individuals Covered

AGREEMENT: I HAVE READ AND AGREE TO THE TERMS OF THE MEMBER CERTIFICATE AND THE INFORMATION ON THE REVERSE SIDE OF THIS FORM.

Employee Signature: _____ Date: _____

**CIGNA HealthCare of
North Carolina Only**

Tier (Current)
 SGL FAM TP ECH ES EC

Tier (Change)
 SGL FAM TP ECH ES EC

Date Proc: _____ By: _____ Pkg. _____

I understand that the benefits for which I (we) will be eligible are in accordance with those described in the Group Master Contract and any changes provided for therein. I also understand that any dependent exceeding the age eligibility requirements must be a full-time student at an accredited college or university, and that failure to provide Proof-of-Enrollment will void this application for coverage for those dependents. CIGNA HEALTHCARE OF NORTH CAROLINA, INC. will periodically request Proof-of-Enrollment.

I authorize my employer to deduct the necessary fees, if any, from my wages or salary with the understanding that he acts as my agent in all dealings with CIGNA HEALTHCARE OF NORTH CAROLINA, INC. and that all acts performed by him and all notices given to him in such dealings are binding upon me, are not prohibited by statute or regulation.

I hereby authorize any person or institution who shall have rendered services to me or to any member of my family unit under a CIGNA HEALTHCARE OF NORTH CAROLINA, INC. contract to make available to CIGNA HEALTHCARE OF NORTH CAROLINA, INC. to such an extent as may be reasonable any photographs, medical records, or other information regarding such services requested by CIGNA HEALTHCARE OF NORTH CAROLINA, INC., which shall be kept confidential by CIGNA HEALTHCARE OF NORTH CAROLINA, INC. I understand that unresolved grievances are subject to the procedure specified in the Group Master Contract.

On behalf of myself and any dependents listed, I hereby apply for coverage under the Group Master Contract issued to my employer by CIGNA HEALTHCARE OF NORTH CAROLINA, INC.

I hereby represent to you that all information furnished by me hereon is true and complete to the best of my knowledge.

CIGNA HEALTHCARE OF NORTH CAROLINA COPY

EMPLOYER'S COPY

EMPLOYEE'S COPY