Enrollment / Change Form - HMO

CIGNA HealthCare of South Carolina, Inc.

Employer: Complete Section A
Employee: Complete Sections B-E

Please print and thank you for providing this information

A

☐ Open Enroll. ☐ Change ☐ New Enroll. ☐ Reinstate	**Effective Date of Add/Change/ Cancellation** (MM/DD/CCYY)	**Employer Name**	**Employer Address**

CIGNA Account No.	**Coverage Type**	**Date of Hire** (MM/DD/CCYY)	**Network ID**	**Branch Code**

TYPE OF CHANGE:

☐ **Add Dependent(s) *** Date: _____
☐ **Cancel Employee** Last Date of Coverage: _____
☐ **Cancel Dependent(s) *** Last Date of Coverage: _____
*** List Names in Section B**

☐ **Address Change**
☐ **Transfer to COBRA**
☐ 18 mos. ☐ 29 mos. ☐ 36 mos.

☐ **Retirement**
☐ **Other** _____

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)*

I Would Like Coverage For Me And My Dependents. ***(Specify last name if different from yours)*** **Last Name First Name M.I.**	**Dependent Social Security No.**	**Date of Birth** MM DD CCYY	**Gender**	**Full Time Student? *** Yes No	***Select your choice of Primary Care Physician (PCP) or HealthCare Center (HCC) and enter the ID Numbers below.***	**Existing Patient?** Yes No	***(check one)***
Employee			☐ M ☐ F		PCP or HCC Choice -	☐ ☐	☐ Add ☐ Cancel
Spouse			☐ M ☐ F		PCP or HCC Choice -	☐ ☐	☐ Add ☐ Cancel
Dependent * Relationship			☐ M ☐ F	☐ ☐	PCP or HCC Choice -	☐ ☐	☐ Add ☐ Cancel
Dependent * Relationship			☐ M ☐ F	☐ ☐	PCP or HCC Choice -	☐ ☐	☐ Add ☐ Cancel
Dependent * Relationship			☐ M ☐ F	☐ ☐	PCP or HCC Choice -	☐ ☐	☐ Add ☐ Cancel

*** DEPENDENTS -** If full time student and age 19 or over, attach proof verifying credit hours. If totally disabled prior to age 19, attach proof of disability for eligibility review.

C

MANAGED CARE MEDICAL OPTIONS:

☐ HMO ☐ Point-of-Service (CHA) ☐ HMO Open Access ☐ Point-of-Service Open Access

D

OTHER HEALTH CARE COVERAGE:

Do you or your dependents have other health insurance under a group plan, HMO, or Medicare? ☐ Yes ☐ No
If yes, please provide the following:

Name of Person Covered	**Social Security No.**	**Effective Date**	**Medicare Part A**	**Medicare Part B**	**Medicaid**	**Other Insurance Carrier**
			☐	☐	☐	☐
			☐	☐	☐	☐

E

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 which I have read and understand.

Employee's Signature / Date	Spouse's Signature / Date	Employer's Signature / Date