Primary Applicant Name _____
Enrollment Form ID _____

Cigna HealthCare of Illinois, Inc./Cigna Health and Life Insurance Company
Illinois Individual and Family Plan Enrollment Application / Change Form

Our HMO medical plans are only available in the following service areas/counties:
HMO: Cook, Kane, Will, Kankakee, and Dupage Counties

Section A. Type of Application

New Enrollment Application:
☐ Applicant Only ☐ Applicant and Dependent(s) ☐ *Child Only
***Must complete one application for each child. Applications containing multiple children will not be accepted.**

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

Requested Effective Date:*
☐ 1st of the Month of_____
Effective dates are assigned to the 1st of the month. Cigna HealthCare of Illinois, Inc./Cigna Health and Life Insurance Company will assign the next available effective date if not selected by the applicant.

** Requested Effective Date cannot be greater than 60 days after the Signature Date. No Effective Dates will be assigned prior to or on the Signature Date without a qualifying life event which allows same day coverage.*

Section B. Enrollment Criteria

Applications are accepted during annual open enrollment period or when an applicant experiences a Qualifying (Triggering) Life Event. Please select the applicable enrollment reason.

☐ Annual Open Enrollment

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

To apply for Special Enrollment Period an applicant must experience a Qualifying (Triggering) Life Event and has 60 days from the date of that event, (including the date of the actual event) to apply for coverage. Triggering events **do not** include loss of coverage due to failure to make premium payments on a timely basis, including COBRA premiums prior to expiration of COBRA coverage; and situations allowing for a rescission under federal law. Please select the applicable qualifying event reason(s) and date(s) below in order to determine your effective date and plan eligibility. Valid documentation will be required to be submitted for all Special Enrollment events.

☐ An eligible individual, and any dependent(s), loses his or her minimum essential coverage for reasons other than the reasons stated above

☐ An eligible individual gained or became a dependent through marriage or civil union

☐ An eligible individual gained or became a dependent through birth, adoption, or placement for adoption, or placement in foster care

☐ An eligible individual experienced an error in enrollment

☐ An eligible individual or enrollee made a permanent move and new coverage is available

☐ An eligible individual and his or her dependent(s) lose employer-sponsored health plan coverage due to 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 employee's becoming entitled to Medicare, divorce or legal separation of the covered employee, and death of the covered employee

☐ An eligible individual loses his or her dependent child status under a parent's employer-sponsored health plan

☐ An eligible individual is mandated to be covered as a dependent pursuant to a valid court order, including child support

For any Special Enrollment Period reason, provide:

Name(s): _____ and Event Date(s): _____

Section C. Benefit Plan Options

Select Desired Medical Benefit Plan:
☐ *Cigna Connect HSA 5500
☐ *Cigna Connect 1200
☐ *Cigna Connect 2500
☐ *Cigna Connect 2750
☐ *Cigna Connect 6250
☐ *Cigna US-IL Connect 3500
☐ *Cigna US-IL Connect 6650

Select Desired Dental Benefit Plan:
☐ Cigna Dental Preventive
☐ Cigna Dental 1500
☐ Cigna Dental 1000

Primary:	☐ Medical	☐ Dental
Spouse (or Domestic Partner/Civil Union):	☐ Medical	☐ Dental
Dependent 1:	☐ Medical	☐ Dental
Dependent 2:	☐ Medical	☐ Dental

Section D. Applicant, Spouse and Dependent Information

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

Date of Birth: | Age: | ☐ Single ☐ Married | ☐ Male ☐ Female | Select your choice of Primary Care Physician (PCP).
First Name: _____ Last Name: _____
PCP ID Number: _____
*Plans with this asterisk mean a PCP is required. If you do not select a PCP, one will be assigned for you.
Current Patient: ☐ Yes ☐ No

Is any applicant enrolled in Medicare? ☐ Yes ☐ No
If you answered "Yes" to the above question, provide names of Medicare enrollees:
_____
For these applicants, please stop here, they are not eligible to enroll in health coverage.

Is any applicant eligible for Medicare? ☐ Yes ☐ No
If you answered "Yes" to the above question, provide names individual(s) eligible for Medicare:
_____

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

Mailing Address – Home Address Required
_____ Street
_____ City County State
_____ ZIP Code (Please provide 9-digit ZIP Code)

Billing Address – If different than mailing address
_____ P.O. Box / Street
_____ City State
_____ ZIP Code

Home Phone Number: ( ) _____-_____
Cell Phone Number: ( ) _____-_____
Work Phone Number: ( ) _____-_____
Email Address:

Applicant's Language Preference
Spoken Language Preference (Select only one)

☐ EN English ☐ ES Spanish ☐ 12 Cantonese ☐ 14 Mandarin ☐ VI Vietnamese ☐ KO Korean ☐ TL Tagalog
☐ HY Armenian ☐ JA Japanese ☐ PS Persian ☐ PA Punjabi ☐ LO Khmer ☐ AR Arabic ☐ 03 White Hmong
☐ 28 Blue/Green Hmong ☐ RU Russian ☐ Declines to State ☐ 99 Other _____
Please Write In

Written Language Preference (Select only one)

☐ EN English ☐ ES Spanish ☐ 20 Traditional Chinese ☐ VI Vietnamese ☐ KO Korean ☐ TL Tagalog ☐ HY Armenian
☐ JA Japanese ☐ PS Persian ☐ PA Punjabi ☐ LO Khmer ☐ AR Arabic ☐ 03 White Hmong ☐ 28 Blue/Green Hmong
☐ RU Russian ☐ Declines to State ☐ 99 Other _____
Please Write In

Spouse/Domestic Partner/Civil Union's Last Name | First Name | M.I. | iTIN: / Social Security Number:

Date of Birth: | Age: | ☐ Single ☐ Married | ☐ Male ☐ Female | Select your choice of Primary Care Physician (PCP).
First Name: _____ Last Name: _____
PCP ID Number: _____
*Plans with this asterisk mean a PCP is required. If you do not select a PCP, one will be assigned for you.
Current Patient: ☐ Yes ☐ No

Is any applicant enrolled in Medicare? ☐ Yes ☐ No
If you answered "Yes" to the above question, provide names of Medicare enrollees:
_____
For these applicants, please stop here, they are not eligible to enroll in health coverage.

Is any applicant eligible for Medicare? ☐ Yes ☐ No
If you answered "Yes" to the above question, provide names individual(s) eligible for Medicare:
_____

Spouse/Domestic Partner/Civil Union's Language Preference
Spoken Language Preference (Select only one)

☐ EN English ☐ ES Spanish ☐ 12 Cantonese ☐ 14 Mandarin ☐ VI Vietnamese ☐ KO Korean ☐ TL Tagalog
☐ HY Armenian ☐ JA Japanese ☐ PS Persian ☐ PA Punjabi ☐ LO Khmer ☐ AR Arabic ☐ 03 White Hmong
☐ 28 Blue/Green Hmong ☐ RU Russian ☐ Declines to State ☐ 99 Other _____
Please Write In

Written Language Preference (Select only one)

☐ EN English ☐ ES Spanish ☐ 20 Traditional Chinese ☐ VI Vietnamese ☐ KO Korean ☐ TL Tagalog ☐ HY Armenian
☐ JA Japanese ☐ PS Persian ☐ PA Punjabi ☐ LO Khmer ☐ AR Arabic ☐ 03 White Hmong ☐ 28 Blue/Green Hmong
☐ RU Russian ☐ Declines to State ☐ 99 Other _____
Please Write In

Dependent children are eligible for coverage up to age 30.
☐ **Check here if you are providing names of additional dependents on an attached separate page.**

Dependent's Last Name	First Name	M.I.	iTIN: / Social Security Number:

Date of Birth:	Age:	☐ Single ☐ Married	☐ Male ☐ Female	Select your choice of Primary Care Physician (PCP). First Name: _____ Last Name: _____ PCP ID Number: _____ *Plans with this asterisk mean a PCP is required. If you do not select a PCP, one will be assigned for you. Current Patient: ☐ Yes ☐ No

Is there a Qualified Medical Child Support Order (*QMCSO)? ☐ Yes ☐ No
*A medical child support order which creates or recognizes the existence of a child's right to receive medical benefits which the responsible parent is eligible for under a health plan.

Dependent's Language Preference
Spoken Language Preference (Select only one)

☐ EN English ☐ ES Spanish ☐ 12 Cantonese ☐ 14 Mandarin ☐ VI Vietnamese ☐ KO Korean ☐ TL Tagalog
☐ HY Armenian ☐ JA Japanese ☐ PS Persian ☐ PA Punjabi ☐ LO Khmer ☐ AR Arabic ☐ 03 White Hmong
☐ 28 Blue/Green Hmong ☐ RU Russian ☐ Declines to State ☐ 99 Other _____
Please Write In

Written Language Preference (Select only one)

☐ EN English ☐ ES Spanish ☐ 20 Traditional Chinese ☐ VI Vietnamese ☐ KO Korean ☐ TL Tagalog ☐ HY Armenian
☐ JA Japanese ☐ PS Persian ☐ PA Punjabi ☐ LO Khmer ☐ AR Arabic ☐ 03 White Hmong ☐ 28 Blue/Green Hmong
☐ RU Russian ☐ Declines to State ☐ 99 Other _____
Please Write In

Dependent's Last Name	First Name	M.I.	iTIN: / Social Security Number:

Date of Birth:	Age:	☐ Single ☐ Married	☐ Male ☐ Female	Select your choice of Primary Care Physician (PCP). First Name: _____ Last Name: _____ PCP ID Number: _____ *Plans with this asterisk mean a PCP is required. If you do not select a PCP, one will be assigned for you. Current Patient: ☐ Yes ☐ No

Is there a Qualified Medical Child Support Order (*QMCSO)? ☐ Yes ☐ No
*A medical child support order which creates or recognizes the existence of a child's right to receive medical benefits which the responsible parent is eligible for under a health plan.

Dependent's Language Preference
Spoken Language Preference (Select only one)

☐ EN English ☐ ES Spanish ☐ 12 Cantonese ☐ 14 Mandarin ☐ VI Vietnamese ☐ KO Korean ☐ TL Tagalog
☐ HY Armenian ☐ JA Japanese ☐ PS Persian ☐ PA Punjabi ☐ LO Khmer ☐ AR Arabic ☐ 03 White Hmong
☐ 28 Blue/Green Hmong ☐ RU Russian ☐ Declines to State ☐ 99 Other _____
Please Write In

Written Language Preference (Select only one)

☐ EN English ☐ ES Spanish ☐ 20 Traditional Chinese ☐ VI Vietnamese ☐ KO Korean ☐ TL Tagalog ☐ HY Armenian
☐ JA Japanese ☐ PS Persian ☐ PA Punjabi ☐ LO Khmer ☐ AR Arabic ☐ 03 White Hmong ☐ 28 Blue/Green Hmong
☐ RU Russian ☐ Declines to State ☐ 99 Other _____
Please Write In

D1. Do all enrollees reside within Illinois and within the service area of the selected benefit plan? ☐ Yes ☐ No
If you answered "No" to the above question, provide names of non residents:
_____

Cigna HealthCare of Illinois, Inc./Cigna Health and Life Insurance Company Use Only:	Effective Date:

Section E. Current Coverage and Additional Prior Coverage Information

To be completed when purchasing a medical plan.
E1. Does any applicant(s) have current health care coverage? ☐ Yes ☐ No

E2. If any applicant answered "Yes" to any of the above, please provide the following information:
Applicants Covered: _____
Most Recent Coverage Start Date: _____ Termination Date: _____

E3. Does this information apply to all family members on this application? ☐ Yes ☐ No
If "No", please add additional coverage information in the space provided below.

Applicant #1 Name: _____
Most recent health coverage start date: (MM/DD/YYYY): _____ Termination date: (MM/DD/YYYY): _____

Applicant #2 Name: _____
Most recent health coverage start date: (MM/DD/YYYY): _____ Termination date: (MM/DD/YYYY): _____

Applicant #3 Name: _____
Most recent health coverage start date: (MM/DD/YYYY): _____ Termination date: (MM/DD/YYYY): _____

To be completed when purchasing a dental plan.
E4. Does any applicant(s) have current dental care coverage? ☐ Yes ☐ No

E5. If any applicant answered "Yes" to any of the above, please provide the following information:
Applicants Covered: _____
Most Recent Coverage Start Date: _____ Termination Date: _____

E6. Does this information apply to all family members on this application? ☐ Yes ☐ No
If "No", please add additional coverage information in the space provided below.

Applicant #1 Name: _____
Most recent dental coverage start date: (MM/DD/YYYY): _____ Termination date: (MM/DD/YYYY): _____

Applicant #2 Name: _____
Most recent dental coverage start date: (MM/DD/YYYY): _____ Termination date: (MM/DD/YYYY): _____

Applicant #3 Name: _____
Most recent dental coverage start date: (MM/DD/YYYY): _____ Termination date: (MM/DD/YYYY): _____

Section F. Health Related Questions

F1. Has any applicant smoked or used tobacco products on average for four (4) or more times per week within the past six months (includes chewing tobacco, cigarettes, cigars and pipes, excludes religious or ceremonial use of tobacco)? ☐ Yes ☐ No

If yes, list applicant name(s) and the last time they smoked or used tobacco products:

Name(s): _____

Section G. Important Information

1. ☐ I prefer to receive written correspondence regarding this application via email.

2. Please do not cancel other current health insurance coverage until written notification is received from Cigna HealthCare of Illinois, Inc./Cigna Health and Life Insurance Company indicating that your application has been approved, and you and your dependents are in receipt of your ID cards.

Section H. 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.

Initial Premium Payment Method: Use this account for my initial and subsequent premium payments.

Account Number:_____ ☐ Checking ☐ Saving

Routing Number: ☐☐☐☐☐☐☐☐☐

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

For Subsequent Premium Payments (If you desire to use a different bank account):

Account Number:_____ ☐ Checking ☐ Saving

Routing Number: ☐☐☐☐☐☐☐☐☐

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

I authorize the Company (Cigna HealthCare of Illinois, Inc./Cigna Health and Life Insurance Company) 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.

Any premium adjustment will automatically be charged to your account. Please be advised that the premium adjustment may reflect an increase.

Credit Card (Available for initial payment only) ☐ VISA ☐ MASTERCARD

Cardholder's Name – exactly as it appears on the card:

Account Number:

☐☐☐☐-☐☐☐☐-☐☐☐☐-☐☐☐☐

Card Expiration Date:

Account Holder's ZIP Code: _____ – _____ 3-digit Code: _____

Any premium adjustment will automatically be charged to your account. Please be advised that the premium adjustment may reflect an increase.

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 I. Statement of Accountability – *To be completed when applicant cannot complete the application.*

I, _____, personally read and completed this Enrollment Application Form for the Applicant named below because:

☐ Applicant does not read English ☐ Applicant does not speak English ☐ Applicant does not write English

☐ Other (explain):_____

I personally translated the contents of this application disclosed by:

_____

I also personally translated and fully explained the Conditions and Agreement Section:

_____ _____

Signature of Translator *required*
(Excludes Parent Signature if Child Only Application)

Today's Date *required*

Section J. Producer Section

Writing Producer Name: Illinois Health Agents Inc.	Producer Code: 8478911	
Street Address:	City:	State: IL ZIP Code:
Email Address: help@ihealthagents.com		
Phone Number: 312.726.6565		
Are you aware of any information about your client not disclosed on this application?		☐ Yes ☐ No
Did you see the proposed applicant at the time this application was completed? If "No", please explain:_____		☐ Yes ☐ No
I verify that the application was completed by the applicant unless otherwise noted in the Statement of Accountability.		
Signature of Writing Producer:		Date:
Please enter the name of the Agency/Producer that checks are to be made payable to if different from Writing Producer.		Producer Code:
Street Address:	City:	State: ZIP Code:
Email Address:		
Phone Number:		
Cigna HealthCare of Illinois, Inc./Cigna Health and Life Insurance Company Sales Representative Last Name:		First Name:

Section K. Contact Information

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

Cigna HealthCare of Illinois, Inc./Cigna Health and Life Insurance Company Individual and Family Plans
P.O. Box 30362
Tampa, FL 33630-3362
FAX # 877.484.5927
www.Cigna.com

Section L. Instructions

- The applicant is responsible for ensuring that the application is complete and truthful.
- Print clearly using black or blue ink.
- The application must be received by Cigna HealthCare of Illinois, Inc./Cigna Health and Life Insurance Company within 30 days from the signature date.
- Coverage will become effective only if this application enrollment form is accepted and appropriate premium is enclosed.
- Do not cancel your current coverage until you have received notification from Cigna HealthCare of Illinios, Inc./Cigna Health and Life Insurance Company.
- Effective dates are generally assigned to the 1st of the month. The next available effective date will be assigned, if not selected by the applicant.

Section M. Conditions and Agreement/Authorization

1. I understand that any person who knowingly and with intent to defraud any insurance company or 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 fraudulent insurance act and may be subject to civil and criminal penalties.
2. I understand that I or my authorized representative is entitled to receive a copy of this authorization form.
3. I understand that information disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and will no longer be protected by federal privacy regulations.
4. If the applicant is a minor, I accept full legal and financial responsibility for the coverage and information provided on this application. (Court documents establishing guardianship must be submitted if the responsible adult is not the parent).

I acknowledge and agree that coverage shall become effective only after (a) this signed Application has been accepted by Cigna HealthCare of Illinois, Inc./Cigna Health and Life Insurance Company , and (b) a contract has been issued by Cigna HealthCare of Illinois, Inc./Cigna Health and Life Insurance Company.

I AGREE ON BEHALF OF MYSELF AND AS AUTHORIZED AGENT OR REPRESENTATIVE OF MY ELIGIBLE DEPENDENTS TO THE PROVISIONS CONTAINED ON THIS FORM, INCLUDING THE PROVISIONS REGARDING THE COLLECTION, USE, AND DISCLOSURE OF PROTECTED HEALTH INFORMATION.

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 an agreement to the conditions listed above.

The above statements are true and complete to the best of my knowledge and belief. I understand and agree that for my child, and/or me and my eligible dependents, these statements shall be the basis for determination of acceptance for coverage under my applicable Cigna HealthCare of Illinois, Inc./Cigna Health and Life Insurance Company benefit plan. I acknowledge and agree that any misrepresentation or intentional omission may render this contract null and void from its date of issue in accordance with applicable law. If my coverage is revoked, I will receive written notice that will explain the decision and my right to appeal. I also understand that I will be required to pay for any services that were covered while a member and that Cigna HealthCare of Illinois, Inc./Cigna Health and Life Insurance Company will refund all amounts paid by me except amounts owed to Cigna HealthCare of Illinois, Inc./Cigna Health and Life Insurance Company.

Primary Applicant Signature:	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)

Section N. Notice to Applicant Regarding Replacement of Accident and Health Insurance (Only complete this section when purchasing a Cigna Policy)

According to information you have furnished, you intend to lapse or otherwise terminate existing accident and health insurance and replace it with a policy to be issued by the insurance carrier. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy.

(1) Health conditions which you may presently have (preexisting conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy.

(2) You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interests to make sure you understand all the relevant factors involved in replacing your present coverage.

(3) If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical/health history. Failure to include all material medical information on an application may provide a basis for the insurance carrier to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, re-read it carefully to be certain that all information has been properly recorded.

(4) It is recommended that you do not terminate your present contract until you are certain that your application for the new contract has been approved by the insurance carrier.

Primary Applicant Name:	Date:
Dependent Name (If submitted separately)	