DENISON UNIVERSITY HEALTH ENROLLMENT / CHANGE FORM

EMPLOYER: Complete Section A
EMPLOYEE: Complete Section B-F

A

Open Enroll ☐ / New Enroll ☐	Change ☐ / Reinstate ☐	Effective Date	Employer Name	Cigna Acct No.	Div./Class	Medical Option	Dental Option
			Denison University	2252190	001		

TYPE OF CHANGE:

Add Dependent(s)	Cancel Dependent(s)	Trans to Cobra	Cancel Employee	Change in Status
Birth ☐ Marriage ☐	Marriage ☐ Divorce ☐	18 mos ☐	Termination of Employment ☐	Retirement ☐
Adoption ☐ Other ☐	Student Status ☐ Other ☐	36 mos ☐	Other Insurance ☐	Surviving Spouse ☐

B

Employee Name (Last)	(First)	(M.I.)	Social Security No.	Home Phone	Work Phone

Address (Street)	(City)	(State)	(ZipCode)

C

I WOULD LIKE COVERAGE FOR ME AND MY DEPENDENTS. (Specify last name if different from yours) Last Name / First Name / MI	DATE OF BIRTH MM DD CCYY	GENDER M / F	COVERAGE SELECTION Medical Dental	FULL TIME STUDENT? Yes No	If you choose Cigna Network enter the Primary Care Physician (PCP) NAME and ID NUMBER below.	EXISTING PATIENT? YES NO	If you choose the Cigna Dental Care (CDC) Option enter the NAME and ID NUMBER below.	EXISTING PATIENT? YES NO
Employee		☐ ☐	☐ ☐	☐ ☐	Name: PCP #	☐ ☐	Name: ID #:	☐ ☐
Spouse		☐ ☐	☐ ☐	☐ ☐	Name: PCP#	☐ ☐	Name: ID#:	☐ ☐
Dependent / Relationship		☐ ☐	☐ ☐	☐ ☐	Name: PCP#	☐ ☐	Name: ID#:	☐ ☐
Dependent / Relationship		☐ ☐	☐ ☐	☐ ☐	Name: PCP#	☐ ☐	Name: ID#:	☐ ☐
Dependent / Relationship		☐ ☐	☐ ☐	☐ ☐	Name: PCP#	☐ ☐	Name: ID#:	☐ ☐

D

MEDICAL OPTIONS:

- ☐ Cigna Network Plan
- ☐ Cigna Open Access Plus
- ☐ Decline Coverage

DENTAL OPTIONS:

- ☐ Cigna Dental Care (CDC)
- ☐ Cigna Dental (PPO)
- ☐ Decline Coverage

E

GROUP BENEFIT CONTRIBUTION:

I would like to pay my share of premiums through payroll with pre tax dollars

☐ YES ☐ NO

F

SIGNATURE - The information provided above is true and correct to the best of my knowledge.

EMPLOYEE'S SIGNATURE / DATE	EMPLOYER'S SIGNATURE / DATE

Revised: 7/07