Instructions

1. Your employer will complete section A.
2. Complete sections B through K.
3. If you are electing medical, complete the section entitled "MEDICAL OPTIONS."
4. Read the *"Disclosure Information"* on the back of the application.
5. Sign and date the application.

We look forward to meeting your family's health care needs.

Employer: Complete Section A **Employee:** Complete Section B-K

Insured and/or Administered by Connecticut General Life Insurance Company
Cigna Health and Life Insurance Company

Cigna.

Enrollment/Change Form

A

☐ OPEN ENROLL ☐ CHANGE ☐ NEW ENROLL ☐ REINSTATE	EFFECTIVE DATE OF CHANGE ADD/CHANGE/CANCELLATION (MM/DD/CCYY) ____/____/____	EMPLOYER NAME	DATE OF HIRE (MM/DD/CCYY) ____/____/____	PLAN NUMBER	SUBGROUP	CLASS

B

☐ SINGLE ☐ MARRIED ____/____/____ ☐ SEPARATED ☐ DIVORCED ☐ WIDOWED	TYPE OF CHANGE ☐ Add Dependent(s) * ☐ Demographics ☐ PCP Change ☐ Retirement * List Name(s) in Section C ☐ COBRA Continuation Qualifying Event Date: ____/____/____ ☐ Other ____________

C

EMPLOYEE NAME *(Last)*	*(First)*		SOCIAL SECURITY NUMBER
EMPLOYEE DATE OF BIRTH (MM/DD/CCYY) ____/____/____	HOME PHONE ( )		
ADDRESS *(Street)*	*(City)*	*(State)*	*(Zip Code)*

☐ YES, I WOULD LIKE COVERAGE FOR MYSELF AND MY DEPENDENTS. (Specify last name if different from yours) Last Name First Name	DEPENDENT SOCIAL SECURITY NUMBER	DATE OF BIRTH (MM/DD/CCYY)	GENDER	HEIGHT	WEIGHT
Employee		/ /	☐M ☐F		
Dependent Relationship		/ /	☐M ☐F		
Dependent Relationship		/ /	☐M ☐F		
Dependent Relationship		/ /	☐M ☐F		
Dependent Relationship		/ /	☐M ☐F		

ADDITIONAL INFORMATION. * DEPENDENTS – If totally disabled prior to age 26, attach proof of disability for eligibility review.

D

	MEDICAL OPTIONS:	EE	EE+SP	EE+CH	EE+FAM
☐	Open Access Plus/__________	☐	☐	☐	☐
☐	Decline Coverage				

E

OTHER HEALTHCARE 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 NUMBER	EFFECTIVE DATE	MEDICARE Part A	MEDICARE Part B	MEDICAID	OTHER INSURANCE CARRIER
		/ /	☐	☐	☐	
		/ /	☐	☐	☐	

F

PAYROLL SIGNATURE **By my signature below, I acknowledge that I have read and understand the disclosure in this application. I authorize the required payroll deduction for contributory benefits. I also represent that all information shown on this application is correct.**

EMPLOYEE SIGNATURE / DATE

G

RELATION TO INSURED	FULL NAME	GENDER	DOB	HEIGHT	WEIGHT	TOBACCO (use during past 5 yrs)
Employee/Self		☐ F ☐ M	/ /	Ft In	Lbs	☐ NO ☐ YES , date last used / / .
Spouse/Domestic Partner		☐ F ☐ M	/ /	Ft In	Lbs	☐ NO ☐ YES , date last used / / .
Child/Dependent		☐ F ☐ M	/ /	Ft In	Lbs	☐ NO ☐ YES , date last used / / .
Child/Dependent		☐ F ☐ M	/ /	Ft In	Lbs	☐ NO ☐ YES , date last used / / .
Child/Dependent		☐ F ☐ M	/ /	Ft In	Lbs	☐ NO ☐ YES , date last used / / .

H

FAMILY MEDICATIONS: Including all oral, topical, optical, nasal, injected or IV infused therapies

Are you or your dependent(s) taking any prescription medication (including any oral, topical, optical, nasal, and injected or IV infused therapies)?
☐ YES ☐ NO **If YES, provide information on all medication currently being taken (attach and sign an additional sheet if necessary).**

Name of Member	Medicine Being Taken	Dosage & Frequency of Use	Date Prescribed	Date Last Taken or Ongoing	Condition(s) Being Taken For
			/ /		
			/ /		
			/ /		
			/ /		

I

HEALTH HISTORY: Including any condition(s) that were diagnosed, consulted on or treated during the past 5 years. If you answer YES to any questions: fill out "Additional Information" section.

During the past 5 years, have you or your dependent(s) been diagnosed with, consulted on, treated or hospitalized for any health condition? (See list of conditions below).

☐ YES ☐ NO	1.	**Heart/Circulatory** including but not limited to: Angioplasty/Stent, Aneurysm, Blood Clots, Blood Disorder, Bypass, Cardiac Arrhythmia, Congestive Heart Failure, Coronary Heart Disease, Heart Murmur, Hemophilia, High Blood Pressure, Peripheral Artery Disease, Pacemaker/Defibrillator, Sickle Cell Anemia, Stroke/TIA (If Stroke/TIA, in add'l information section include information regarding any residuals/complications/degree of recovery) or Ventricular Tachycardia
☐ YES ☐ NO	2.	**Eyes/Ears/Nose/Throat** including but not limited to Acoustic Neuroma, Cleft Lip/Palate, Deviated Septum or Retinopathy
☐ YES ☐ NO	3.	**Immune** including but not limited to AIDS/HIV+, CIDP, Immuno Deficiency, Lupus, Psoriasis or Scleroderma
☐ YES ☐ NO	4.	**Cancer/Tumors** provide details below regarding type, stage/level of advancement, if it has spread beyond the original site, radiation/chemotherapy, any surgeries completed/pending/expected.
☐ YES ☐ NO	5.	**Neurological** including but not limited to ASL, Myasthenia Gravis, Cerebral Palsy, Multiple Sclerosis, Paralysis/Hemiplegia/Quadriplegia or Seizures/Convulsions/Epilepsy
☐ YES ☐ NO	6.	**Transplants** provide details below regarding transplant(s) completed, pending, expected or discussed, type of transplant (BMT, stem cell, specific organ) and any complications or signs of rejection.
☐ YES ☐ NO	7.	**Arthritis** including but not limited to Osteoarthritis or Rheumatoid Arthritis
☐ YES ☐ NO	8.	**Bones/Muscles/Joints** including but not limited to Bulging/Herniated Disk, Fibromyalgia, Joint Replacement, Knee Problem/Disorder, Muscular Dystrophy, Neck/Back Pain or Disorder, Regional Pain Syndrome/Chronic Pain or Spina Bifida. If Joint Replacement, include the date of replacement in the Additional Information section below.
☐ YES ☐ NO	9.	**Liver/Kidney/Urinary** including but not limited to Bladder Disorder, Prostate Disorder, Liver Disease/Disorder, Hepatitis (include information regarding type), Cirrhosis, Kidney Disease/Disorder, Renal Failure (list if chronic or end stage) or Dialysis (provide information below including type - hemo or peritoneal, Medicare eligible date and expected Medicare primary date).
☐ YES ☐ NO	10.	**Endocrine/Metabolism** including but not limited to Diabetes, Neuropathy/Other Complications, Fabry's Disease, Gaucher's Disease, Growth Hormone Deficiency/Dwarfism or Hurler's Disease If Diabetic, provide additional information below including whether it is controlled by diet, oral medication or insulin.
☐ YES ☐ NO	11.	**Reproductive** including but not limited to Endometriosis, Fibroids or Ovarian Cysts
☐ YES ☐ NO	12.	**Lung/Respiratory** including but not limited to Asthma, COPD/Emphysema (include information below on whether an oxygen tank is being used), Cystic Fibrosis, Lung Disorder, Sarcoidosis, Sleep Apnea or Tuberculosis.
☐ YES ☐ NO	13.	**Intestinal** including but not limited to Crohn's Disease, Diverticulitis/Diverticulum, Gallbladder Disorder, Gastric Bypass, Pancreatitis or Ulcerative Colitis
☐ YES ☐ NO	14.	**Psychological** including but not limited to Alcoholism, Bipolar, Depression, Substance Abuse, Eating Disorder or Schizophrenia
☐ YES ☐ NO	15.	**Current Pregnancy** include in additional information section below information regarding due date, complications, if C-Section is expected or if multiple births are expected, include the number of babies.
☐ YES ☐ NO	16.	**Any Other Condition Not Listed Above** - provide additional information below.

J

ADDITIONAL INFORMATION **"If more space is needed for your responses, please attach the additional information on a separate page and sign and date the page."**

Name of Member	Condition/Specific Diagnosis	Diagnosis/Treatment (Including surgeries completed or expected and complications)	Diagnosis Date	Treatment Status and Date Last Treated	Comments
			/ /		
			/ /		
			/ /		
			/ /		

MUWComp1.0

K

I understand that I will not be individually denied coverage or be individually charged different rates as a result of my answers.
However, if I knowingly provide false information on this Questionnaire, I understand and agree that it may affect the payment of claims or result in termination of my/or my dependent(s) coverage.

EMPLOYEE SIGNATURE:	Today's Date: (MM/DD/YYYY) / /	Daytime Phone Nbr: ( ) -	Email:

DISCLOSURE INFORMATION

I hereby apply for all non-contributory coverages under my employer's plan and any contributory coverages that I have elected on the front of this application.

Health coverage

I understand that I must submit a Certificate or evidence of prior creditable coverage to receive credit towards the satisfaction of any pre-existing condition limitation specified in my employer's plan; and to be eligible for credit, the gap between the two coverages must be 63 days or less.

I and/or my eligible dependent(s) will be considered a *"Special Applicant"* if:

- I did not previously elect to cover myself and/or my eligible dependent(s) under my employer's policy/plan because of other health coverage and I later apply because the other coverage terminated due to exhausting the maximum of COBRA coverage or due to loss of eligibility for coverage due to legal separation, divorce, death, termination of employment or reduction in the number of hours of employment; or
- I did not previously elect to cover myself and/or my eligible dependent(s) and I later apply for coverage because of a change in my family status resulting from marriage, birth or adoption or placement for adoption of a child, or a court has ordered me to provide coverage for my dependents; or

I understand that to qualify as a *"Special Applicant"* I must apply for health coverage for myself and/or my eligible dependent(s) within 31 days after:

- Coverage under the prior health plan ends; or I marry; or I acquire a new child through birth, adoption or placement of a child for adoption.

I will be considered a late applicant if:

- I fail to qualify as a *"Special Applicant"* because I did not apply within the 31 days as specified above; or
- I did not previously elect to cover myself and/or my eligible dependents and I later apply.
- My employer offers multiple health plans and I have decided to elect a different plan during the open enrollment period.

As a late applicant applying for health coverage, I realize that I may only be allowed entrance to the plan during the open enrollment period. As a late applicant, I realize that my entry to the plan may be subject to special enrollment requirements and that I must contact my Plan Administrator for details.

For all coverages

Caution: Any person who, knowingly and with intent to defraud any insurance company or other person: (1) files an application for insurance or statement of claim containing any materially false information; or (2) conceals for the purpose of misleading, information concerning any material fact thereto, commits a fraudulent insurance act.

Colorado Residents: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

District of Columbia Residents: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

Florida Residents: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Kentucky Residents: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

Maryland Residents: Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

New Jersey Residents: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

New York Residents: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Oklahoma residents: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

Oregon Residents: Any person who knowingly and with intent to defraud any insurance company or other person: (1) files an application for insurance or statement of claim containing any materially false information; or (2) conceals for the purpose of misleading, information concerning any material fact, may have committed a fraudulent insurance act.

Pennsylvania Residents: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Tennessee Residents: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

Texas Residents: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Virginia Residents: Any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated state law.