

STEP 3: Enroll Now. FUNDAMENTAL

A CIGNA HealthCare Product

1-800-000-0000

www.fundamentalcare.com



Group # _____

Medical/Dental Enrollment Form

Please return form to your HR Department

Connecticut General Life Insurance Company • P.O. Box 55270 • Phoenix, AZ • 85078-5270

New Coverage Request for Change Status Group Name _____
 COBRA Continuee Decline/Waive Coverage Transaction Effective Date _____

1. Employee Information:

First Name _____ MI _____ Last Name _____ Sex - Male Female
Date of Birth _____ Social Security Number _____ Marital Status - Single Married
Home Address _____ City _____ State _____ Zip Code _____
Home Phone Number _____ Employer Name _____
Division/Position/Location _____ Date of Hire _____ Hourly Salary

2. Plan Options:

Medical Only Medical and Dental

3. Who Should Be Covered

Myself Only Myself and 1 Dependent Myself and Spouse Family

4. Decline/Waiver

I decline coverage: Yes, I want to decline coverage for myself/my dependents.

I choose to waive coverage: Yes, I want to waive coverage for myself/my dependents.

Note: If you are waiving coverage for yourself and your dependents, because of coverage under other health coverage, you are required to complete this section. Your failure to do so may cause you or your dependents to be considered a late enrollee if you enroll in this plan at a later date.

Other Health Plan Name _____

5. Coordination of Benefits

Are you, your spouse, or any of your dependents covered under any other Medical Health plan? Yes No

Is another person legally responsible for coverage of your children? Yes No

If you answered yes to either of the questions above, please complete the following:

Policy Holder with Other Health Plan _____ Policy Holder's ID Number _____

Health Plan Name _____ Employer Group Name and Number _____

1. Dependent Covered - Name _____ Date of Birth _____ Sex - Male Female
2. Dependent Covered - Name _____ Date of Birth _____ Sex - Male Female
3. Dependent Covered - Name _____ Date of Birth _____ Sex - Male Female

6. Coverage Information

(A) Add / (T) Term / (C) Chg

____ Employee First Name _____ MI _____ Last Name _____
____ Spouse First Name _____ MI _____ Last Name _____ Social Security Number _____
____ Zip Code _____ Date of Birth _____ Sex - Male Female / Disabled* - Yes No / Full-Time Student Over 19* - Yes No
____ Child 1 First Name _____ MI _____ Last Name _____ Social Security Number _____
____ Zip Code _____ Date of Birth _____ Sex - Male Female / Disabled* - Yes No / Full-Time Student Over 19* - Yes No
____ Child 2 First Name _____ MI _____ Last Name _____ Social Security Number _____
____ Zip Code _____ Date of Birth _____ Sex - Male Female / Disabled* - Yes No / Full-Time Student Over 19* - Yes No

*If yes, provide proof at time of enrollment.

7. Authorization

For Maryland residents only. Any person who, with intent to defraud or knowing that he is facilitating fraud against an insurer, submits an application or files a claim containing a false or deceptive statement commits a crime of insurance fraud as determined by a court of law.

For Oregon residents only. Any person who knowingly and with intent to defraud or solicit another to defraud an insurer: (1) by submitting an application, or (2) by filing a claim containing a false statement as to any material fact, may be violating state law.

For Louisiana and Montana residents only. Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Employee Signature _____ Date _____ Employer Signature _____

FC-ENRL-01

Fundamental Care is not a major medical plan.