CIGNA HealthCare

Membership Application & Change Form
Welcome To Cigna HealthCare!

- Please be sure to complete this Membership Application & Change Form (Membership Application) in its entirety and retain the PINK copy as it will serve as your temporary ID Card. All (applicable) sections of the Membership Application must be complete in order for CIGNA HealthCare to process your Membership Application. Failure to complete the Membership Application will delay the commencement of coverage.
- When filling-out this Membership Application, please be sure to also complete a Standardized Health Form. The Standardized Health Form should be sent to CIGNA HealthCare at PO Box 2010, Concord, NH 03302-2010. If you don't have a copy, your employer can provide one to you or you can download the form from our website:
  - www.cigna.com/health/producer/smallgroup/
  - Select "New Hampshire" from the drop-down menu on the left.
  - Select "Document Library" from the center of the page.
  - Select "Standardized Health Form (SHF)" under "New Hampshire New Group Documents."
- Be sure to complete **all sections** of the Standardized Health Form (with the exception of Policy/Group Number (in Section One) for groups new to CIGNA HealthCare).
- You must complete and return the Membership Application (to your employer) and the Standardized Health Form (to CIGNA HealthCare) within 31 days of your proposed effective date of coverage. Failure to do so will delay the commencement of coverage.
- When you join a CIGNA HealthCare HMO Plan, each member of your family must choose a Primary Care Physician (PCP) to coordinate medical care. You can access the Provider Directory online at www.cigna.com or call Member Services at the number listed on your ID card if you need assistance in selecting a PCP.

How To Complete This Application

1 COVERAGE TYPE / SUBSCRIBER INFORMATION
The employee should complete this section. If you are joining CIGNA HealthCare for the first time, please check the NEW SUBSCRIBER box.

2 SUBSCRIBER AND DEPENDENT(S) INFORMATION
Complete this section for yourself, your spouse and any dependent(s) to be covered under the Plan.

3 PRIMARY CARE PHYSICIAN (First and Last Name)
Indicate your Primary Care Physician (PCP) selection here. HMO Members must list a PCP. You may refer to the Provider Directory in your CIGNA HealthCare packet, access the Provider Directory online at www.cigna.com or call a Member Services Representative at the number listed on your CIGNA HealthCare ID Card for assistance in selecting a PCP.

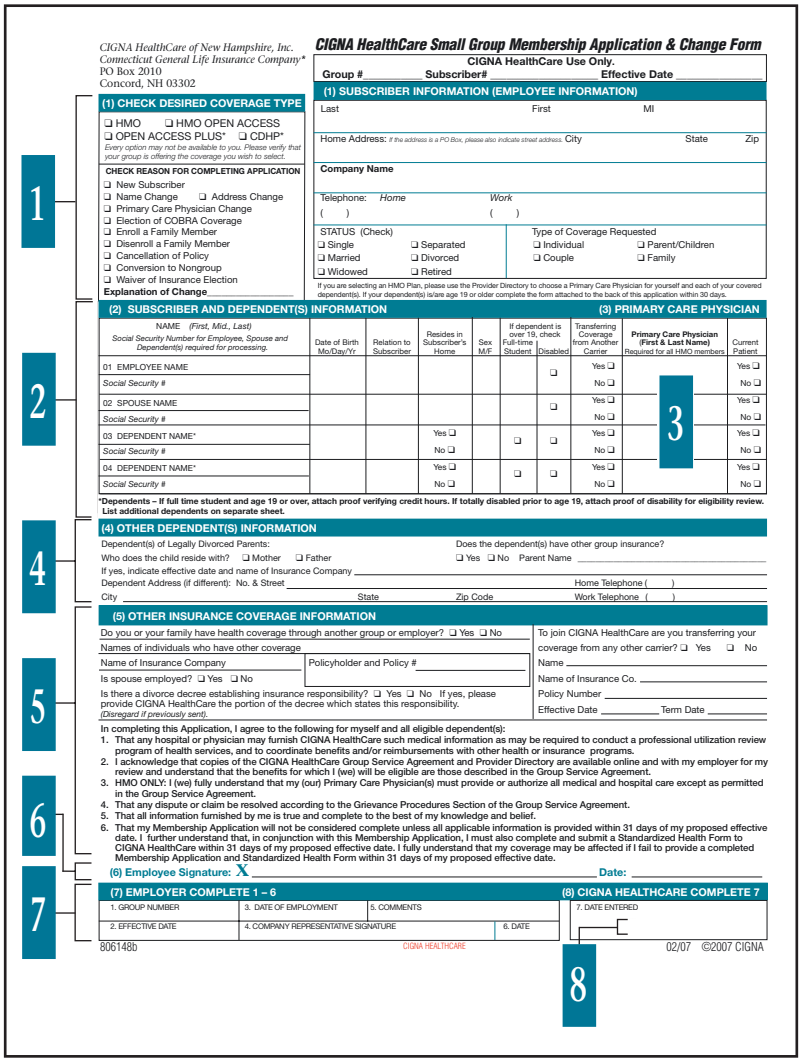
4 OTHER DEPENDENT(S) INFORMATION
Specific questions for divorced parents with dependents. Complete this section only if applicable.

5 OTHER INSURANCE COVERAGE INFORMATION
If you are transferring from another Group Health Plan of if you will have other coverage along with this Plan, please complete this section.

6 EMPLOYEE SIGNATURE
Employee must sign and date this Membership Application.

7 EMPLOYER COMPLETE (1-6)
After completing sections 1 through 6, return the Membership Application to your employer to fill-in Group Number, Date of Employment, Comments, Effective Date, Signature and Date.

8 CIGNA HEALTHCARE COMPLETE (7)
To be completed by CIGNA HealthCare.



CIGNA HealthCare of New Hampshire, Inc.
*Connecticut General Life Insurance Company**
PO Box 2010
Concord, NH 03302

CIGNA HealthCare Small Group Membership Application & Change Form

CIGNA HealthCare Use Only.
Group # _____ Subscriber# _____ Effective Date _____

(1) CHECK DESIRED COVERAGE TYPE
❑ HMO ❑ HMO OPEN ACCESS
❑ OPEN ACCESS PLUS* ❑ CDHP*
Every option may not be available to you. Please verify that your group is offering the coverage you wish to select.

CHECK REASON FOR COMPLETING APPLICATION
❑ New Subscriber
❑ Name Change ❑ Address Change
❑ Primary Care Physician Change
❑ Election of COBRA Coverage
❑ Enroll a Family Member
❑ Disenroll a Family Member
❑ Cancellation of Policy
❑ Conversion to Nongroup
❑ Waiver of Insurance Election
Explanation of Change_____

(1) SUBSCRIBER INFORMATION (EMPLOYEE INFORMATION)
Last First MI
Home Address: *If the address is a PO Box, please also indicate street address.* City State Zip
Company Name
Telephone: *Home* ( ) *Work* ( )
STATUS (Check) ❑ Single ❑ Separated ❑ Married ❑ Divorced ❑ Widowed ❑ Retired
Type of Coverage Requested ❑ Individual ❑ Parent/Children ❑ Couple ❑ Family
If you are selecting an HMO Plan, please use the Provider Directory to choose a Primary Care Physician for yourself and each of your covered dependent(s). If your dependent(s) is/are age 19 or older complete the form attached to the back of this application within 30 days.

(2) SUBSCRIBER AND DEPENDENT(S) INFORMATION — (3) PRIMARY CARE PHYSICIAN

NAME (First, Mid., Last) Social Security Number for Employee, Spouse and Dependent(s) required for processing.	Date of Birth Mo/Day/Yr	Relation to Subscriber	Resides in Subscriber's Home	Sex M/F	If dependent is over 19, check Full-time Student	If dependent is over 19, check Disabled	Transferring Coverage from Another Carrier	Primary Care Physician (First & Last Name) Required for all HMO members	Current Patient
01 EMPLOYEE NAME						❑	Yes ❑ No ❑		Yes ❑ No ❑
Social Security #									
02 SPOUSE NAME						❑	Yes ❑ No ❑		Yes ❑ No ❑
Social Security #									
03 DEPENDENT NAME*			Yes ❑ No ❑		❑	❑	Yes ❑ No ❑		Yes ❑ No ❑
Social Security #									
04 DEPENDENT NAME*			Yes ❑ No ❑		❑	❑	Yes ❑ No ❑		Yes ❑ No ❑
Social Security #									

*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. List additional dependents on separate sheet.

(4) OTHER DEPENDENT(S) INFORMATION
Dependent(s) of Legally Divorced Parents:
Does the dependent(s) have other group insurance? ❑ Yes ❑ No Parent Name
Who does the child reside with? ❑ Mother ❑ Father
If yes, indicate effective date and name of Insurance Company
Dependent Address (if different): No. & Street Home Telephone ( )
City State Zip Code Work Telephone ( )

(5) OTHER INSURANCE COVERAGE INFORMATION
Do you or your family have health coverage through another group or employer? ❑ Yes ❑ No
Names of individuals who have other coverage
Name of Insurance Company Policyholder and Policy #
Is spouse employed? ❑ Yes ❑ No
Is there a divorce decree establishing insurance responsibility? ❑ Yes ❑ No If yes, please provide CIGNA HealthCare the portion of the decree which states this responsibility. *(Disregard if previously sent).*
To join CIGNA HealthCare are you transferring your coverage from any other carrier? ❑ Yes ❑ No
Name
Name of Insurance Co.
Policy Number
Effective Date Term Date

In completing this Application, I agree to the following for myself and all eligible dependent(s):
1. That any hospital or physician may furnish CIGNA HealthCare such medical information as may be required to conduct a professional utilization review program of health services, and to coordinate benefits and/or reimbursements with other health or insurance programs.
2. I acknowledge that copies of the CIGNA HealthCare Group Service Agreement and Provider Directory are available online and with my employer for my review and understand that the benefits for which I (we) will be eligible are those described in the Group Service Agreement.
3. HMO ONLY: I (we) fully understand that my (our) Primary Care Physician(s) must provide or authorize all medical and hospital care except as permitted in the Group Service Agreement.
4. That any dispute or claim be resolved according to the Grievance Procedures Section of the Group Service Agreement.
5. That all information furnished by me is true and complete to the best of my knowledge and belief.
6. That my Membership Application will not be considered complete unless all applicable information is provided within 31 days of my proposed effective date. I further understand that, in conjunction with this Membership Application, I must also complete and submit a Standardized Health Form to CIGNA HealthCare within 31 days of my proposed effective date. I fully understand that my coverage may be affected if I fail to provide a completed Membership Application and Standardized Health Form within 31 days of my proposed effective date.

(6) Employee Signature: X _____ Date: _____

(7) EMPLOYER COMPLETE 1 – 6 — (8) CIGNA HEALTHCARE COMPLETE 7

1. GROUP NUMBER	3. DATE OF EMPLOYMENT	5. COMMENTS	7. DATE ENTERED
2. EFFECTIVE DATE	4. COMPANY REPRESENTATIVE SIGNATURE	6. DATE	

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Questions? Call Member Services at the number listed on your CIGNA HealthCare ID Card.

CIGNA HealthCare of New Hampshire, Inc.
*Connecticut General Life Insurance Company**
PO Box 2010
Concord, NH 03302

CIGNA HealthCare Small Group Membership Application & Change Form

CIGNA HealthCare Use Only.
Group #_____ **Subscriber#** _____ **Effective Date** _____

(1) CHECK DESIRED COVERAGE TYPE

❑ HMO ❑ HMO OPEN ACCESS
❑ OPEN ACCESS PLUS* ❑ CDHP*
Every option may not be available to you. Please verify that your group is offering the coverage you wish to select.

CHECK REASON FOR COMPLETING APPLICATION

❑ New Subscriber
❑ Name Change ❑ Address Change
❑ Primary Care Physician Change
❑ Election of COBRA Coverage
❑ Enroll a Family Member
❑ Disenroll a Family Member
❑ Cancellation of Policy
❑ Conversion to Nongroup
❑ Waiver of Insurance Election
Explanation of Change_____

(1) SUBSCRIBER INFORMATION (EMPLOYEE INFORMATION)

Last First MI

Home Address: *If the address is a PO Box, please also indicate street address.* City State Zip

Company Name

Telephone: *Home* *Work*
( ) ( )

STATUS (Check)
❑ Single ❑ Separated
❑ Married ❑ Divorced
❑ Widowed ❑ Retired

Type of Coverage Requested
❑ Individual ❑ Parent/Children
❑ Couple ❑ Family

If you are selecting an HMO Plan, please use the Provider Directory to choose a Primary Care Physician for yourself and each of your covered dependent(s). If your dependent(s) is/are age 19 or older complete the form attached to the back of this application within 30 days.

(2) SUBSCRIBER AND DEPENDENT(S) INFORMATION — (3) PRIMARY CARE PHYSICIAN

NAME *(First, Mid., Last)* / *Social Security Number for Employee, Spouse and Dependent(s) required for processing.*	Date of Birth Mo/Day/Yr	Relation to Subscriber	Resides in Subscriber's Home	Sex M/F	If dependent is over 19, check Full-time Student	Disabled	Transferring Coverage from Another Carrier	**Primary Care Physician (First & Last Name)** Required for all HMO members	Current Patient
01 EMPLOYEE NAME						❑	Yes ❑		Yes ❑
Social Security #							No ❑		No ❑
02 SPOUSE NAME						❑	Yes ❑		Yes ❑
Social Security #							No ❑		No ❑
03 DEPENDENT NAME*			Yes ❑		❑	❑	Yes ❑		Yes ❑
Social Security #			No ❑				No ❑		No ❑
04 DEPENDENT NAME*			Yes ❑		❑	❑	Yes ❑		Yes ❑
Social Security #			No ❑				No ❑		No ❑

***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. List additional dependents on separate sheet.**

(4) OTHER DEPENDENT(S) INFORMATION

Dependent(s) of Legally Divorced Parents:
Who does the child reside with? ❑ Mother ❑ Father

Does the dependent(s) have other group insurance?
❑ Yes ❑ No Parent Name _____

If yes, indicate effective date and name of Insurance Company _____

Dependent Address (if different): No. & Street _____ Home Telephone ( )

City _____ State Zip Code Work Telephone ( )

(5) OTHER INSURANCE COVERAGE INFORMATION

Do you or your family have health coverage through another group or employer? ❑ Yes ❑ No

Names of individuals who have other coverage

Name of Insurance Company

Policyholder and Policy #

Is spouse employed? ❑ Yes ❑ No

Is there a divorce decree establishing insurance responsibility? ❑ Yes ❑ No If yes, please provide CIGNA HealthCare the portion of the decree which states this responsibility.
(Disregard if previously sent).

To join CIGNA HealthCare are you transferring your coverage from any other carrier? ❑ Yes ❑ No

Name _____

Name of Insurance Co. _____

Policy Number _____

Effective Date _____ Term Date _____

In completing this Application, I agree to the following for myself and all eligible dependent(s):

1. That any hospital or physician may furnish CIGNA HealthCare such medical information as may be required to conduct a professional utilization review program of health services, and to coordinate benefits and/or reimbursements with other health or insurance programs.
2. I acknowledge that copies of the CIGNA HealthCare Group Service Agreement and Provider Directory are available online and with my employer for my review and understand that the benefits for which I (we) will be eligible are those described in the Group Service Agreement.
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(6) Employee Signature: X _____ **Date:** _____

(7) EMPLOYER COMPLETE 1 – 6

1. GROUP NUMBER	3. DATE OF EMPLOYMENT	5. COMMENTS
2. EFFECTIVE DATE	4. COMPANY REPRESENTATIVE SIGNATURE	6. DATE

(8) CIGNA HEALTHCARE COMPLETE 7

7. DATE ENTERED

CIGNA HealthCare

HMO Members Only

CIGNA HealthCare of New Hampshire, Inc.
PO Box 2010
Concord, NH 03302

NEW SUBSCRIBER: Thank you for choosing CIGNA HealthCare. Please keep the pink copy of this Membership Application for your records; it will serve as your temporary ID Card until your actual ID Card is sent to you. As soon as your enrollment becomes effective, CIGNA HealthCare is responsible for providing access to health care services that are covered under your Plan. Please call your Primary Care Physician (PCP) for regular appointments, urgent care and medical emergencies.

FOR APPOINTMENTS: Call your Primary Care Physician.

FOR EMERGENCY CARE: When appropriate, call your Primary Care Physician and follow the physician's instructions. In the instance of a medical emergency, go to the nearest Emergency Room for care and notify your Primary Care Physician as soon as possible to ensure that your claim is eligible for coverage.

OUT-OF-AREA CARE: If you have a medical emergency or urgent care need while you are away from home, you may see any physician for treatment. However, you must notify your Primary Care Physician within 48 hours to ensure that your claim is eligible for coverage and that your PCP coordinates any required follow-up care.

QUESTIONS? The CIGNA HealthCare Member Services Department is available to answer your questions. You can reach Member Services at the number listed on your CIGNA HealthCare ID card.

