Primary Applicant Name_____
Enrollment Form ID_____

Connecticut General Life Insurance Company and
CIGNA HealthCare of Arizona, Inc. ('CIGNA')

Arizona Individual Plan Enrollment Application / Change Form

Section A. Type of Application

New Enrollment Application:
☐ Applicant Only ☐ Applicant and Dependent(s) ☐ Child(ren) Only

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_____
☐ 15th of the Month of _____
Effective dates are assigned to the 1st or 15th of the month. Underwriting 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.*

Section B. Benefit Plan Options

Select Desired Benefit Plan:
☐ **HMO Select Network*:** ☐ CIGNA Medical Group ☐ Arizona Provider Network
***Phoenix Service Area:** Covers Maricopa and City of Apache Junction. Applicants can select from CIGNA Medical Group Network or Arizona Provider Network.*
***Tucson and southern Arizona Service Area:** Covers Pima, Pinal, Graham, Greenlee, Cochise and Santa Cruz counties. Applicants in these areas can select a PCP from the Arizona Provider Network.*
☐ Arizona Open Access Plans: ☐ 1,000/80% ☐ 2,000/80% ☐ 3,000/80% ☐ 5,000/80% ☐ 7,500/100% ☐ 10,000/100%
☐ Arizona Open Access Value Plans: ☐ 1,500/70% ☐ 2,500/70% ☐ 3,000/70% ☐ 5,000/70% ☐ 7,500/70% ☐ 10,000/70%
☐ Arizona Health Savings Plans: ☐ 1,500 ☐ 3,000 ☐ 5,000

Section C. Applicant, Spouse and Dependent Information

Applicant's Last Name		First Name				M.I.	Social Security Number
Date of Birth	Age	☐ Single ☐ Married	☐ Male ☐ Female	Height Ft.	In.	Weight (Lbs.)	Primary Care Physician ID Number (HMO Only) _____ Primary Care Physician ID Number Optional (OAP Only) _____ Current Patient: ☐ Yes ☐ No
Mailing Address – Home Address Required Street City State ZIP Code		Billing Address – If different than mailing address Street City State ZIP Code				County Email Address:	Home Phone Number: ( ) _____-_____ Cell Phone Number: ( ) _____-_____ Work Phone Number: ( ) _____-_____
Applicant's Spouse Last Name		First Name				M.I.	Social Security Number
Date of Birth	Age	☐ Single ☐ Married	☐ Male ☐ Female	Height Ft.	In.	Weight (Lbs.)	Primary Care Physician ID Number (HMO Only) _____ Primary Care Physician ID Number Optional (OAP Only) _____ Current patient: ☐ Yes ☐ No
Dependent children are covered up to age 26. ☐ Check here if you are providing names of additional dependents on an attached separate page.							
Applicant's Dependent Last Name		First Name				M.I.	Social Security Number
Date of Birth	Age	☐ Single ☐ Married	☐ Male ☐ Female	Height Ft.	In.	Weight (Lbs.)	Primary Care Physician ID Number (HMO Only) _____ Primary Care Physician ID Number Optional (OAP Only) _____ Current Patient: ☐ Yes ☐ No

Primary Applicant Name_____ Enrollment Form ID_____

Applicant's Dependent Last Name		First Name			M.I.	Social Security Number
Date of Birth	Age	☐ Single ☐ Married	☐ Male ☐ Female	Height	Weight	Primary Care Physician ID Number (HMO Only) _____ Primary Care Physician ID Number Optional (OAP Only) _____
				Ft. In.	(Lb)	Current Patient: ☐ Yes ☐ No

C1. Is any applicant listed on this enrollment form a non-citizen resident of the U.S.? ☐ Yes ☐ No

C2. If "Yes," has the applicant(s) resided within the U.S. in the last consecutive 6 months? ☐ Yes ☐ No If "No," provide name(s) and explain:

CIGNA Use Only | Effective Date

Section D. Prior / Current Coverage Information

1. Has any person applying for coverage been covered within the last 63 days from the signature date? ☐ Yes ☐ No
   Persons Covered:_____ Termination date:_____
   Prior or Current Health Plan Carrier:_____
   Is current coverage still in effect? ☐ Yes ☐ No
2. Has any applicant applying for coverage ever been declined, had a waiver applied or had a premium adjustment for life, disability or health insurance, or had such insurance plan rescinded? ☐ Yes ☐ No If "Yes", provide the following information:
   Name of Applicant:_____ Explanation:_____
3. Is any applicant applying for coverage eligible for Medicare? ☐ Yes ☐ No
   Applicant Name:_____
4. Has any applicant applying for coverage ever filed a claim or received benefits for disability insurance or Workers' Compensation? ☐ Yes ☐ No
   If "Yes," provide details: Name:_____ Dates:_____ Condition(s):_____
5. Each applicant must agree to cancel all other health policies or plans, including HMO or PPO coverage, providing benefits for health services similar to this plan.

Section E. Health Questionnaire

All questions must be answered and complete details provided to all "Yes" answers for Sections E and F in Section G.

Has any applicant listed on this application, in the past ten (10) years, had any signs, symptoms, been made aware of, seen a health care provider, had treatment recommended including prescription medication, laboratory tests or X-rays/CT scans/MRIs, received treatment, or been hospitalized for the following conditions or diseases as stated in questions numbers E1 through F18? This is not an all inclusive list and the categories below do not limit your health information responses.

Any illness or condition that may occur or be discovered between the signature date and the effective date of coverage must be reported to CIGNA. This information may be used to determine the final underwriting decision.

E1. Brain/Nervous/Behavior/Emotional	**YES**	**NO**	**E2. Eyes, Ears, Nose, Throat**	**YES**	**NO**
Loss of consciousness, fainting, dizziness	☐	☐	Eyes/sight: glaucoma, cataracts, crossed eyes, detached retina, corneal transplant, infections, retinopathy	☐	☐
Numbness, tingling, weakness, paralysis, hemiplegia	☐	☐	Ears/Hearing: loss of hearing, deafness, infections, Eustachian tube dysfunction, acoustic neuroma	☐	☐
Confusion, memory loss, Alzheimer's disease, dementia	☐	☐	Nose/breathing: deviated septum, polyps, adenoiditis, sinusitis	☐	☐
Head injury, stroke	☐	☐	Throat/swallowing: tonsillitis, strep throat, excessive snoring, sleep apnea	☐	☐
Migraine headaches, chronic severe headaches	☐	☐	Other:	☐	☐
Narcolepsy, sleep apnea or used a sleep monitoring device	☐	☐	**E3. Heart/Circulatory**	☐	☐
Tremors, Seizures/epilepsy	☐	☐	Anemia, bleeding/clotting disorders, hemophilia, stroke, TIA	☐	☐
Multiple sclerosis, Muscular Dystrophy, Parkinson's disease, Cerebral Palsy	☐	☐	Varicose/spider veins, Raynauds, phlebitis, thrombosis	☐	☐
Reflex Sympathetic Dystrophy (RSD)	☐	☐	Enlarged lymph nodes or lymphadenitis	☐	☐
Depression, anxiety, attention deficit, chemical imbalance	☐	☐	Chest pain, angina, congestive heart disease/failure, coronary artery disease	☐	☐
Bi-polar, obsessive-compulsive, panic disorders, psychosis, schizophrenia	☐	☐	Heart attack, bypass surgery/angioplasty, valve disease/replacement, pacemaker/defibrillator	☐	☐
Suicide attempt	☐	☐	High/low blood pressure, hypertension, high cholesterol/lipids	☐	☐
Eating disorders, anorexia/bulimia	☐	☐	Heart murmur, irregular heartbeat, palpitations	☐	☐
ADHD/Hyperactivity, autism, developmental delay	☐	☐	Aneurysm, rheumatic fever	☐	☐
Alcohol or chemical dependence, substance abuse	☐	☐	Other:	☐	☐
Psychotherapy, counseling or support group	☐	☐			

E4. Respiratory/Lungs	YES	NO
Allergies, sinusitis, bronchitis, asthma	☐	☐
Pneumonia, shortness of breath, chronic cough, collapsed lung, sleep apnea	☐	☐
Emphysema, COPD, Cystic Fibrosis	☐	☐
Tuberculosis, fungal infections, difficulty breathing, or spitting/coughing up blood?	☐	☐
Other:	☐	☐

E5. Skin	YES	NO
Acne, birthmarks, dermatitis, eczema, psoriasis	☐	☐
Fungal infections, warts, moles	☐	☐
Pre-cancerous lesions, skin cancers or melanoma	☐	☐
Herpes	☐	☐
2nd or 3rd degree burns, scars/keloid	☐	☐
Cosmetic or reconstructive surgery	☐	☐
Other:	☐	☐

E6. Digestive	YES	NO
Infections of the mouth/throat/tonsils, problems with jaw, chewing or swallowing	☐	☐
Ulcers, hernia, gastric/acid reflux, GERD	☐	☐
Colitis, Crohn's disease, Irritable Bowel Syndrome (IBS), chronic diarrhea	☐	☐
Intestinal problems, colon polyps, rectal bleeding or hemorrhoids	☐	☐
Diseases of the pancreas, liver, or gallbladder	☐	☐
Hepatitis A/B/C/other, jaundice, cirrhosis	☐	☐
Unexplained weight loss or gain, eating disorder or gastric bypass/ banding?	☐	☐
Other:	☐	☐

E7. Musculoskeletal	YES	NO
Disorders or injuries of bones, joints, muscles, ligaments, tendons, disc disease/disorder	☐	☐
Strain/sprain, fracture, bone spur	☐	☐
Arthritis	☐	☐
Fibromyalgia, gout, osteoporosis, polio	☐	☐
Herniated disc, chronic neck pain, chronic back pain	☐	☐
Joint replacement, internal/external fixations, permanent hardware	☐	☐
Amputation, prosthesis	☐	☐
Other:	☐	☐

E8. Urinary	YES	NO
Bladder infections, kidney infections, cystitis, kidney stones	☐	☐
Blood in urine, painful/difficult urination, frequency	☐	☐
Stress incontinence, bed wetting, neurogenic bladder	☐	☐
Polycystic kidney disease, renal failure, renal dialysis	☐	☐
Other:	☐	☐

E9. Endocrine/Metabolic/Glandular/Hormonal	YES	NO
Diabetes	☐	☐
Thyroid disorders, adrenal/pituitary disorders	☐	☐
Lupus, scleroderma, chronic fatigue syndrome, Epstein-Barr, mononucleosis	☐	☐
AIDS/ARC, any immune disorder (not including the results for the HIV test)	☐	☐
Other:	☐	☐

E10. Male Reproduction	YES	NO
Fertility/Infertility, low sperm count	☐	☐
Sexual dysfunction, erectile dysfunction	☐	☐
Enlarged prostate, Benign Prostatic Hypertrophy (BPH), prostatitis, undescended testes	☐	☐
Genital / anal herpes, sexually transmitted diseases	☐	☐
Other:	☐	☐

E11. Cancer/Tumors	YES	NO
Cysts, tumors, or abnormal growths	☐	☐
Hodgkin's disease, leukemia, lymphoma, other cancer, or malignancy	☐	☐
Received Chemotherapy within the last 10 years	☐	☐
Other:	☐	☐

E12. Birth Defects/Congenital Abnormalities	YES	NO
Birthmarks, cleft palate/lip, club foot, webbed fingers/toes	☐	☐
Mental retardation, Down's syndrome, Cerebral Palsy	☐	☐
Heart/lung/kidney malformation, skull/facial, other physical deformities	☐	☐
Other:	☐	☐

E13. Female Reproduction	YES	NO
a) Pelvic pain, abnormal menstrual bleeding, absence of menstruation, abnormal PAP smear	☐	☐
Endometriosis, ovarian cysts, uterine fibroids, miscarriage	☐	☐
Breast cyst/lump/fibroids, breast implants	☐	☐
Genital warts/herpes, sexually transmitted diseases	☐	☐
Other:	☐	☐

	YES	NO
b) Has any applicant undergone infertility/fertility testing or received assisted reproductive therapy?	☐	☐
If "Yes," provide complete detail in Section G.		
c) Has it been more than 40 days since her/their last menstrual period?	☐	☐
If "Yes," provide Name:_____		
Reason/Explain:_____		

E13. Female Reproduction	YES	NO		YES	NO
d) Is any female applicant currently pregnant, tested positive with a home pregnancy test, or in the process of adoption or becoming a surrogate? If "Yes," provide Name:_____	☐	☐	**e)** Has any female applicant had an abnormal Pap smear? If yes, has there been a subsequent normal pap smear result? Date of last abnormal result: _____Date of last normal result:_____ **f)** Has any female applicant had an abnormal mammogram? If "Yes," has there been a subsequent normal mammogram result? Date of last abnormal result: _____Date of last normal result:_____ Provide complete detail in Section G	☐ ☐ ☐ ☐	☐ ☐ ☐ ☐

Section F. Health Related Questions	YES	NO
F1. Is any male applicant expecting a child or in the process of adoption or surrogacy with anyone, whether or not listed on this application?	☐	☐
F2. Has any applicant been treated or diagnosed for alcohol, chemical or substance abuse, or been advised to reduce alcohol intake within the past 10 years? Name:_____	☐	☐
F3 Has any applicant ever used illegal, controlled drugs (prescription medications) or substances, such as marijuana, cocaine, methamphetamine, illegal or IV drugs within the past 10 years? Name:_____Type of drug/substance:_____Date discontinued_____	☐	☐
F4. Has any applicant consumed any alcoholic beverage in the last 6 months? (Amount: A drink is a 12 oz. of beer, 6 oz. of wine or 1 oz. of liquor) Name:_____Type:_____Amount:_____ per day ☐ week ☐ month ☐ Name:_____Type:_____Amount:_____ per day ☐ week ☐ month ☐	☐	☐
F5. Has any applicant had their driver's license suspended or restricted within the past 10 years? If "Yes," check name and reason: Name:_____ ☐ Medical Condition ☐ DUI/DWI ☐ Prescribed Medication Name:_____ ☐ Medical Condition ☐ DUI/DWI ☐ Prescribed Medication	☐	☐
F6. Has any applicant been arrested or convicted of a DUI or DWI (drunken driving violation) within the past 10 years? If "Yes," provide Name:_____State:_____Date(s):_____ Name:_____State:_____Date(s):_____	☐	☐
F7. Has any applicant ever been diagnosed or treated for AIDS (Acquired Immune Deficiency Syndrome) or AIDS-related conditions, or tested positive for antibodies to the Human Immunodeficiency Virus (HIV)?	☐	☐
F8. Has any applicant taken prescription medications or been advised to take prescription medication in the past 2 years? If "Yes," complete Section G and H.	☐	☐
F9. In the last 10 years, has any applicant had an abnormal physical exam, laboratory result, x-ray, EKG, MRI, CT scan or been advised to undergo further testing, surgery or treatment?	☐	☐
F10. In the past 10 years, has any applicant seen, received treatment from or consulted any person providing health care services for any condition not listed on this application? If yes, complete Section G.	☐	☐
F11. Has any applicant been a patient in a hospital, outpatient clinic, surgical center, treatment center or other medical facility in the last 10 years? If "Yes," complete Section G.	☐	☐
F12. Has any applicant consulted a health care provider for any condition or symptom(s) in the last **12 months** for which a diagnosis has not been established?	☐	☐
F13. Has any applicant been advised to see a periodontist or oral surgeon in the last **12 months (excluding normal checkups)?**	☐	☐
F14. Has any applicant used tobacco products, including chewing tobacco, cigarettes, cigars, pipes in the past 2 years? If yes, complete to following: a.) Name(s):_____ b.) ☐ Cigarettes ☐ Cigars ☐ Pipe ☐ Chewing Tobacco c.) Quantity per day: _____ d.) How many years? _____ e.) Has the person(s) quit? ☐ Yes ☐ No f.) If yes, when _____	☐	☐
F15. Has any applicant ever received health services or pre-screening lab testing from a health fair or other vendor? If "Yes," provide applicant name and detail in Section G.	☐	☐
F16. Has any applicant ever received or been recommended to have follow up or future diagnostic testing? If "Yes," provide applicant name and detail in Section G.	☐	☐
F17. Is any applicant a candidate for, or a recipient of, an organ, bone marrow, or stem cell transplant?	☐	☐
F18. Is any applicant currently on the donor waiting list and/or registered to donate an organ or bone marrow (excluding DMV card)?	☐	☐

Section G. Detailed Health Information
If you answered 'YES' to any of the questions in Sections E and F, you must provide complete details below.
☐ Check here if you are attaching additional pages.

Question #______	Applicant's Name:
Condition, Illness, Diagnosis	From Month/Yr ______________ To Month/Yr______________
Describe Treatment, Testing, Prognosis – Provide Details	Name / Address and Phone of Health Care Provider/Facility: ______________________________ ______________________________ ______________________________
Ongoing symptoms/treatment or follow-up treatment needed? ☐ Yes, list details:______________________________ ☐ No, all treatment complete	

Question #______	Applicant's Name:
Condition, Illness, Diagnosis	From Month/Yr ______________ To Month/Yr______________
Describe Treatment, Testing, Prognosis – Provide Details	Name / Address and Phone of Health Care Provider/Facility: ______________________________ ______________________________ ______________________________
Ongoing symptoms/treatment or follow-up treatment needed? ☐ Yes, list details:______________________________ ☐ No, all treatment complete	

Question #______	Applicant's Name:
Condition, Illness, Diagnosis	From Month/Yr ______________ To Month/Yr______________
Describe Treatment, Testing, Prognosis – Provide Details	Name / Address and Phone of Health Care Provider/Facility: ______________________________ ______________________________ ______________________________
Ongoing symptoms/treatment or follow-up treatment needed? ☐ Yes, list details:______________________________ ☐ No, all treatment complete	

Section H.
List all prescription medication and/or samples received from your health care provider taken by you and your dependents within the past 2 years.
☐ Check here if you are attaching additional pages.

Applicant Name	Question Number	Name of Medication, Dosage, Frequency	Date Prescribed Mo/Day/Yr	Date Discontinued Mo/Day/Yr	Reason/Condition/ Diagnosis	Prescribing Physician/ Health Care Provider

Section I.
If any applicant answered "YES" to Section E3 for Elevated Cholesterol, Triglycerides, and/or High Blood Pressure/Hypertension, please complete the details required in the table below.
☐ Check here if you are attaching additional pages.

Applicant Name	Date of Result	Cholesterol	Triglycerides	HDL	LDL	DATE	Blood Pressure Reading
Reading within last 12 months							

Section J.
Has any applicant experienced a weight change greater than 20 pounds in the past 12 months? If you answered "YES", please complete details in the following section.
☐ Check here if you are attaching additional pages.

Applicant's Name	Weight Change Within Last 12 Months	Cause For Weight Change
	☐ Gained_________ Lbs. ☐ Lost_________ Lbs.	☐ Diet ☐ Medication ☐ Pregnancy ☐ Unknown
	☐ Gained_________ Lbs. ☐ Lost_________ Lbs.	☐ Diet ☐ Medication ☐ Pregnancy ☐ Unknown

Section K.

List last visit to Doctor or Person providing care (including checkup) – Complete for ALL family members listed on this application.

☐ Check here if you are attaching additional pages.

Applicant's Name	Date of Visit/Service	Reason for Visit	Results		Please provide complete detail for Health care provider below.
			Normal √	Abnormal – explain findings	
					Name: _____ Phone: _____ Address: _____ City: _____ State ____ ZIP Code: _____
					Name: _____ Phone: _____ Address: _____ City: _____ State ____ ZIP Code: _____

Section L. Important Information

1. CIGNA will enroll all eligible family members unless otherwise instructed.
   ☐ I, the applicant, instruct that CIGNA not enroll any eligible applicants unless ALL family members are approved for coverage.

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

3. Applicants applying for coverage may be declined or receive a premium adjustment based on information CIGNA receives during the underwriting and enrollment process. Written communication containing confidential details will be sent to you if any applicant is declined coverage or if a premium adjustment is applied. If all applicants are declined coverage, the premium will be refunded.

4. Please do not cancel other current health insurance coverage until written notification is received from CIGNA indicating that your application has been approved and you and your dependents are in receipt of your ID cards.

5. CIGNA may decline coverage for any of the applicants identified in this application based on answers to questions about current or past health status. CIGNA also may set premium rates higher than standard quoted rates based on answers to such questions. If you do not want an applicant or dependent enrolled at an increased premium, you must instruct CIGNA accordingly:
   ☐ I, the applicant, instruct CIGNA to enroll the remaining applicants if an applicant is denied.
   ☐ I wish to have applicants automatically enrolled at the final rate, even if the rate is higher than the quoted rate; OR
   ☐ I wish to review rates that are higher than standard before deciding whether to accept coverage.

Section M. Payment Method

NOTE: Easy Pay and Credit Card are the only payment methods allowed for online or faxed applications. The accounts will be charged upon approval of your Application.

Easy Pay – (Electronic Fund Transfer – EFT)

☐ Yes, I am requesting Easy Pay option for my initial payment and for ongoing monthly payments **(no paper or electronic monthly billing statement will be issued)**.

Account Number_____ ☐ Checking ☐ Saving

Routing Number: ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

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

I authorize the Company (CIGNA HealthCare) 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 health care 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 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 made during underwriting process will automatically be charged to your account. Please be advised that the premium adjustment may reflect an increase of 400% of the standard rate.

Credit Card (Available for initial payment only)	☐ VISA ☐ MASTERCARD
Cardholder's Name – exactly as it appears on the card:	
Account Number ☐☐☐☐-☐☐☐☐-☐☐☐☐-☐☐☐☐ Account Holder's ZIP Code ____ ____ ____ ____ ____ – ____ ____ ____ ____	Card Expiration Date

Any premium adjustment made during underwriting process will automatically be charged to your account.
Please be advised that the premium adjustment may reflect an increase of 400% of the standard rate

For Paper Application: ***Please check here:*** ☐ Paper check is attached or ☐ Credit card information provided.

Ongoing Payment Options if selecting Paper Check or Credit Card for initial payment (please select one option only)

☐ Yes, I am submitting a Personal check (or have selected the Credit Card option) for my initial payment and I am requesting the Personal check payment for ongoing quarterly payments (monthly billing option is not available for this ongoing payment method).

☐ Yes, I am submitting a Personal check for my initial payment (or have selected the Credit Card option) and I am requesting Easy Pay for ongoing monthly payments. (No paper or electronic monthly or quarterly billing statements will be issued.) ***Please complete Easy Pay Section.***

☐ Yes, I am submitting a Personal check (or have selected the Credit Card option) for my initial payment and I am requesting monthly electronic bills (eBills) and will initiate a payment online for ongoing monthly payments.

For Online electronic submitted Application:
Ongoing Payment Options if Credit Card Option was selected for initial payment (please select one option only).

☐ Yes, I agree to recurring automatic Easy Pay option for my ongoing monthly payments. (No paper or electronic monthly billing statement will be issued.)

☐ Yes, I am requesting to receive monthly electronic bills (eBills) and will initiate a payment online for ongoing monthly payments.

Section N. Statement of Accountability – *To be completed when applicant can not 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 and, to the best of my knowledge, obtained and listed all the personal and medical information 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 O. Producer Section		
Writing Producer Name:		Producer Code:
Street Address:	City:	State: ZIP Code:
Email Address:		
Phone Number:		
Are you aware of any information about your client not disclosed on this application? If "Yes", please explain:_____		☐ 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 Sales Representative Last Name:		First Name:

Section P . 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 the CIGNA HealthCare underwriting team within 30 days from the signature date.
- Any misrepresentation or intentional omission regarding the presence of pre-existing conditions, diseases, or other medical condition of any applicant will render this contract null and void from its date of issue in accordance with applicable law.
- Coverage will become effective only if this application enrollment form is approved and appropriate premium is enclosed.
- Coverage is not guaranteed until you receive written notification from CIGNA HealthCare. Do not cancel your current coverage until you have received notification from CIGNA HealthCare.
- You are ineligible for coverage if applicant is currently pregnant, or in the process of adoption or surrogacy, or a non-citizen applicant that has not resided in the U.S. for the past 6 consecutive months.
- Effective dates are assigned to the 1st or 15th of the month. Underwriting will assign the next available effective date if not selected by the applicant.

Section Q. Conditions and Agreement/Authorization

1. HMO applicants: I understand that the Primary Care Physicians may be network-affiliated and that my choice of Primary Care Physician may affect the hospitals, specialty care, and other providers to which or whom I am referred. OAP and HSP applicants: I understand that under the CIGNA plan in which I am enrolling, I will be entitled to lesser benefits if I use an out-of-network hospital, physician or other healthcare facility. HMO plans are issued by CIGNA HealthCare of Arizona, Inc. Open Access plans and Health Savings plans are issued by Connecticut General Life Insurance Company.
2. I understand that during the application process and after my enrollment, CIGNA HealthCare of Arizona, Inc. and other direct or indirect subsidiaries of CIGNA Corporation (collectively "CIGNA") may obtain and provide Confidential Information to others. For purposes of this Paragraph and Paragraph 3 and 4 below, "Confidential Information" means Medical Record Information, Payment Records, Protected Health Information and/or Privileged Information as defined by applicable law; dental; disability; accident; or workers' compensation related information, and expressly includes the following: CONFIDENTIAL HIV-RELATED INFORMATION (AS DEFINED IN A.R.S. § 20-448.01), CONFIDENTIAL COMMUNICABLE DISEASE-RELATED INFORMATION (AS DEFINED IN A.R.S.§ 20-448.02), CONFIDENTIAL ALCOHOL OR DRUG ABUSE TREATMENT OR RELATED INFORMATION (AS DEFINED IN 42 C.F.R.§ 2.1 ET SEC.), CONFIDENTIAL MENTAL HEALTH DIAGNOSIS/TREATMENT INFORMATION, CONFIDENTIAL PSYCHOTHERAPY NOTES (AS DEFINED IN 42 C.F.R. § 164.501), AND CONFIDENTIAL GENETIC TESTING INFORMATION (AS DEFINED IN A.R.S. § 20-448.02).
3. I authorize any insurance institution, employer, provider, insurance support organization, health care organization, and their agents and representatives to provide Confidential information on request by CIGNA to representatives of CIGNA who are authorized by CIGNA to receive such information, to any CIGNA participating provider, or to any other provider, person or entity performing a service for the following purposes: establishing eligibility under the Plan, Plan administration, validating services and benefits payable under the Plan, performance of peer review, utilization management, quality assurance, grievance and appeals, care management, and/or to access the quality of or access to health care services and supplies. I further authorize CIGNA (through its agents and representatives who are authorized by CIGNA to disclose confidential information) to provide Confidential Information to the person or entities above when it determines that such disclosure is necessary or appropriate for the purpose specified in this paragraph or as otherwise authorized by applicable state or federal law, including the Health Insurance Portability and Accountability Act (HIPAA) Privacy Standards (45 C.F.R. Parts 160 and 164, Subpart E). I understand confidential HIV-related information will be disclosed only in accordance with A.R.S. §20-448.01 (C) and will not be released without signed patient authorization.

   I authorize CIGNA to request my and/or my dependents' (those who are applying for coverage under this enrollment form) medical records, any prescribed medication history, and any other medical or pharmaceutical information to underwrite this enrollment form for coverage, make eligibility, risk rating, policy issuance and enrollment determinations for the subscriber and all dependents. I authorize any physician, other healthcare professionals, hospitals, clinics, labs, pharmacies, pharmacy benefit managers or any other healthcare organization ("Providers") that provided treatment or any other service to me and/or any of my dependents applying for coverage under this enrollment form to disclose the information required by CIGNA and described above to CIGNA and/or its designated agents. The existence of such information and documentation as described above shall be disclosed under this Enrollment Form. I understand that CIGNA will rely on such information to: 1) underwrite this enrollment form for coverage, make eligibility, risk rating, policy issuance and enrollment determinations for all of the subscribers; 2) administer claims and determine or fulfill responsibility for coverage and provisions of benefits; 3) administer coverage; and 4) conduct other insurance operations according to federal and state laws and regulations.

   I authorize CIGNA to use such information and to disclose such information to affiliates, Providers, payors, other insurers, third party administrators, vendors, consultants, governmental authorities with jurisdiction when necessary for my care or treatment, payment for services, the operation of my health plan, or to conduct related activities.
4. I am providing authorization for myself and as agent or representation of my spouse and any dependent children. I understand that this authorization will remain in effect until I send written notice revoking it to CIGNA or for such shorter period as required by law. I understand that to the extent this authorization applies to information collected in connection with this application for coverage, the authorization is valid for a period of thirty (30) months. I further understand that to the extent this authorization applies to information collected in connection with a claim for benefits under the Plan, the authorization is valid for and with respect to services received during the term of coverage under the Plan. Until revoked by me or by operation of law, this authorization remains in effect and may be relied on by CIGNA and other parties.
5. 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.
6. I authorize that payment be made under Part B of Medicare to CIGNA for medical and other services furnished by CIGNA for which it pays or has paid, if applicable.
7. I agree that in the event health services provided or covered are the primary responsibility of Medicare, workers' compensation coverage, automobile medical payment coverage, or other payments source CIGNA may be authorized by applicable law to pursue, to fully inform CIGNA and execute such documents and provide such assistance as may be necessary to enable CIGNA to recover the value of services provided, arranged or covered.
8. I understand that I or my authorized representative is entitled to receive a copy of this authorization form.
9. 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.

I acknowledge and agree that coverage shall become effective only after (a) this signed Application has been accepted upon review of the health history I have provided and any medical information reviewed by CIGNA, and (b) a contract has been issued by CIGNA.

I understand that any illness or conditions that may occur or be discovered between the date of my application and the effective date of coverage must be reported to CIGNA. In such event, I further understand that my application may again be reviewed by CIGNA to determine final approval.

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 MEDICAL AND PROTECTED HEALTH INFORMATION. EXPENSES, IF ANY, ASSOCIATED WITH OBTAINING MEDICAL RECORDS ARE THE APPLICANTS FINANCIAL RESPONSIBILITY.

PLEASE NOTE: If you are applying for a medically underwritten plan, there is a waiting period for pre-existing conditions. Services for pre-existing conditions are not covered until 12 months after the contract effective date. A pre-existing condition is one for which medical advice, diagnosis, care, or treatment was recommended or received within 6 months before an individual's enrollment effective date under the contract. A genetic condition is not a pre-existing condition in the absence of a diagnosis of the condition related to the genetic information. If you are applying for an HMO plan, there is no pre-existing condition waiting period, except that CIGNA does have a waiting period of 21 months from the effective date of the contract for maternity services coverage (beyond pregnancy complications). Waiting periods for pre-existing conditions do not apply to anyone under 19 years of age.

All applicants 18 years and older must sign and date application, acknowledging their understanding of and 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 benefit plan. I acknowledge and agree that any misrepresentation or intentional omission regarding the presence of pre-existing conditions, diseases, or other medical condition of any applicant will 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 will refund all amounts paid by me except amounts owed to CIGNA.

Applicant Signature	Today's Date (MM/DD/YYYY)	Applicant Spouse's Signature	Today's Date (MM/DD/YYYY)
Applicant's Dependent Age 18 or Older	Today's Date (MM/DD/YYYY)	Applicant's Dependent Age 18 or Older	Today's Date (MM/DD/YYYY)

Section R. Contact Information

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

CIGNA Individual Plan
P.O. Box 30362
Tampa, FL 33630-3362

FAX # 1.877.484.5927

www.CIGNAforYou.com

If you have questions about completing this application, please call CIGNA at 1.866.GET.CIGNA (1-866-438-2446) 8:00 AM - 8:00 PM ET

Section S. Authorization to Release Information to CIGNA for Pre-Enrollment Processing

TO APPLICANT FOR HEALTH PLAN COVERAGE: *CIGNA needs to review your health information to finish processing your application. Thus, it is very important that you immediately sign, date and return this Authorization to give us permission to review your records. If you do not sign and return this Authorization, we may deny your application for coverage because it is incomplete.*

I voluntarily authorize disclosure (either through paper documents, electronic communication, or orally):

OF WHAT: Information about my health maintained in underwriting, eligibility or other files of a health insurer or health maintenance organization, or in medical or patient files of a health care provider, or elsewhere, including, but not limited to: reasons I was rejected for health insurance coverage; medication history; diagnosis, testing and test results, prognosis, and treatment of any physical condition, including Human Immunodeficiency Virus (HIV), Acquired Immune Deficiency Syndrome (AIDS) or other related syndromes or complexes, communicable diseases or disorders or sexually transmitted diseases; genetic information and test results; domestic abuse information; drug, alcohol, or other substance abuse information, including information about treatment or therapy; information related to mental conditions, including diagnoses, treatment plans and medications prescribed *(excluding only notes by a mental health professional analyzing or documenting conversations during private therapy sessions and maintained separately from the medical record)*.

FROM WHOM: Any insurance institution, employer, provider, insurance support organization, health care organization, and their agents and representatives.

TO WHOM: CIGNA, companies affiliated with CIGNA or other persons or entities authorized by CIGNA to receive the records described above.

FOR WHAT PURPOSE: To allow CIGNA to determine if I am eligible for insurance coverage under CIGNA.

EXPIRES WHEN: Twenty-four (24) months after the date I sign this Authorization.

I further agree to or acknowledge the following:

- I authorize use of a copy of this form (including an electronic copy) for the disclosures requested above.
- I understand that I have the right to revoke this Authorization at any time by sending a written statement to CIGNA at the address listed in the contact section of the application or by providing written notice to the doctor, insurance company or others who disclosed the information. However, the revocation will not be effective if the information already has been disclosed to CIGNA and CIGNA has relied on the information.
- Any agreements I have made to restrict my protected health information do not apply to this Authorization, and I instruct the persons and organizations identified above to release and disclose all my information without restriction.
- A health care provider or health plan providing me coverage cannot refuse to provide me services based on my failure to sign an Authorization. **However, I understand that because CIGNA cannot obtain information necessary to process my application without this Authorization, CIGNA can deny my application if I do not sign this Authorization, or if I alter or revoke the Authorization.**
- CIGNA is subject to the "HIPAA" federal Privacy Rules. Therefore, information disclosed by providers or health plans pursuant to this Authorization will continue to be protected by the HIPAA Privacy Rules and will not be subject to further disclosure except as allowed by those rules.

I understand that I or my authorized representative is entitled to receive a copy of this authorization form.

All applicants 18 years and older must sign and date authorization.

Applicant Signature:	Today's Date: (MM/DD/YYYY)	Applicant Spouse's Signature:	Today's Date: (MM/DD/YYYY)
Dependent Applicant Age 18 or Older:	Today's Date: (MM/DD/YYYY)	Dependent Applicant Age 18 or Older:	Today's Date: (MM/DD/YYYY)