CIGNA / ASBA Employer Group Application

You have received this information under the assumption that you are an asba member.

You are eligible for the CIGNA Health Insurance on the 1st of the month following 90 days of asba membership.

Name of Company: ____

Nature of Business: ____

Address: ____

Phone #: ____________________________________ Fax #: ______________________________________

Email: ____

Contact Name: ______________________________________ Date joined asba: ______________________

Do you currently have medical coverage? ________ Insurance Company_____________________________

Total # of employees________________ #Full-Time__________________ #Part -Time___________________

# of full time employees waiving coverage due to coverage under another health plan_____________________

Contribution Percentage: Employee________________________ Dependent___________________________

Please initial these items and return this form along with your application and payment.

_____I understand that there is a monthly administration charge of:

- Medical plan—$20.00
- Groups NOT participating in medical plan—$6.00

_____I understand that my benefits will be cancelled should this administration charge not be paid each month.

_____I understand that there is a late fee charge of $15.00 if the premium is not paid by the 10th of the current month.

_____I understand that my benefits could be terminated if this late fee charge is not paid.

_____I understand that if my premium check is ever returned for "insufficient funds" that there will be an additional charge of $35.00.

_____I understand that if this "insufficient funds" charge is not paid, my benefits could be terminated.

_____I understand that the second month's premium initially submitted with my application is, in fact, the escrow premium that is used to pay either my premium, should I be late, or my last month's premium should I terminate. If coverage is terminated due to lack of payment this is not considered a COBRA qualifying event and coverage cannot be reinstated until the next open enrollment.

_____I understand that if the escrow is used to pay my premium, it must be replaced along with any additional fees by the end of the month it has been applied to or my benefits could be terminated.

Signature_______________________________ Title______________________ Date___________

This form must be returned along with your application in order to be processed.