Enrollment / Change Form (Consolidated)

asba arizona small business association | Cigna | unum | vsp Vision care for life

Mail to: Arizona Small Business Benefits | 4600 E. Washington St. #340 | Phoenix, AZ 85034 or Fax to: 602.306.4001

Part A Employer ▼

Employer Name: Employer ID: Employer Address:

☐ Open Enrollment ☐ New Enrollment ☐ Change ☐ Add Dependent ☐ Hire Date ___/___/___ ☐ Effective Date ___/___/___

Part B Employee(s) ▼ ☐ Cancel Coverage (please state reason) ▶ _____

Last First Middle: Social Security Number:

___/___/___ Date of Birth: Home Phone: Work phone: Cell: Email:

Address: City: State: Zip: Job Title:

☐ I would like Coverage for me and my Dependents

▼ (If you select HMO or DHMO please list your Physician + ID number) ▼

Last Name / First Name / M.I. (specify last name if different from yours)	Social Security Number	Date of Birth	Coverage Secection	Medical Primary Care Physician (HMO) and provider number	Dental Primary Care Physician (DHMO) and provider number
Spouse:			Medical ☐ Dental ☐ Vision ☐		
Dependent:			Medical ☐ Dental ☐ Vision ☐		
Dependent:			Medical ☐ Dental ☐ Vision ☐		
Dependent:			Medical ☐ Dental ☐ Vision ☐		

Part C Plans Available ▶

CIGNA Medical:
- ☐ High Deductible Plan 1
- ☐ High Deductible Plan 2
- ☐ Low Option HMO

CIGNA Dental:
- ☐ Dental PPO
- ☐ Dental HMO

VSP Vision:
- ☐ Enhanced Plan B
- ☐ Plan C

☐ **Unum Life:** (Please fill out attached beneficiary information) ▶
- ☐ Enroll
- ☐ I elect dependent life coverage
- ☐ I do not elect dependent life coverage

Date of hire ___/___/___

Other Health Care Coverage:
Do you or your dependents have other health insurance under a individual plan, group plan, HMO, or Medicare?

☐ yes (If yes, please provide the following) ▼ ☐ no

Medicare
☐ ☐ Part B ☐ Medicaid ☐ Other insurance

Name of person covered: Social Security Number: Effective Date: Insurance Company Name: Account or Group number:

Signature - The information provided above is true and correct to the best of my knowledge, and I accept the provisions of this form which I have read and understand

X Employee's Signature / Date: ***X Spouse's Signature / Date:*** ***X Employer's Signature / Date:***

Completion and Submission of this Application does not Guarantee Coverage

▼ If you have elected UNUM life please fill out and read the following ▼

Name: (last, first, middle)	relation to you:	Benefit %
If the Beneficiary(ies) named above are not living, then pay:		

Limitations and Exclusions

DELAYED EFFECTIVE DATE:

Employee: Insurance will be delayed for employees not in active employment until the first of the month, coincident with or next, following the date they return to work. Regularly scheduled vacation time is considered active employment. Dependents: Coverage for totally disabled dependents will be delayed until the first of the month, coincident with or next, following the date the individual is no longer disabled. This delay does not apply to newborn children while dependent insurance is in effect. “Totally disabled” means that, as a result of injury, a sickness or a disorder, your dependent is confined in a hospital or similar institution; is unable to perform two or more activities of daily living (ADLs) because of a physical or mental incapacity resulting from an injury or a sickness; is cognitively impaired; or has a life threatening condition.
EXCLUSION FOR SUICIDE:

Where the cause of death is suicide:

1. No benefits will be payable for a loss occurring within 24 months after the individual’s initial effective date; and
2. No increased or additional insurance will be payable for a loss occurring within 24 months after the day such increased or additional insurance is effective.

This Suicide Exclusion does not apply to Washington residents.

AD&D BENEFIT EXCLUSIONS

AD&D Benefits would not be paid for losses caused by, contributed to by, or resulting from:

- Disease of the body or diagnostic, medical or surgical treatment or mental disorder as set forth in the latest edition of the Diagnostic and Statistical Manual of Mental Disorders;
- Suicide, self-destruction while sane, or self-inflicted injury;
- War, declared or undeclared, or any act of war;
- Active participation in a riot;
- Attempt to commit or commission of a crime;
- The voluntary use of any prescription or non-prescription drug, poison, fume or any other chemical substance unless used according to the prescription or direction of the individual’s doctor. This exclusion does not apply to the individual if the chemical substance is ethanol; or
- Intoxication. (“Intoxicated” means that the individual’s blood alcohol level equals or exceeds the legal limit for operating a motor vehicle in the state or jurisdiction where the accident occurred.)

Unum is a registered trademark and marketing brand of Unum Group and its insuring subsidiaries.

Retain a copy of this form for your records

▼ If you have selected CIGNA Medical or Dental please read the following ▼

PROVISIONS

CIGNA HealthCare” refers to various operating subsidiaries of CIGNA Corporation. Products and services are provided by these subsidiaries and not by CIGNA Corporation. These subsidiaries include Connecticut General Life Insurance Company, Tei-Drug, Inc. and its affiliates, CIGNA Behavioral Health, Inc. Intracorp, and HMO or service copany subsidiaries of CIGNA Health Corporation and CIGNA Dental Health, Inc.

I agree, for myself and my dependents, that, in the event any health services provided are the primary responsibility of any other party by way of other group health coverage or by the act or omission of another person to fully inform the healthplan and will execute such assignments, liens or other documnets which may be necessary to enable the healthplan to recover the value of the services provided. I further agree that in the event I or any of my dependents collect benefits or damages from any other party who has responsibility for services provided by the healthplan, I will immediatly reimburse the healthplan to the extent of services provided, to the extent premitted by state law.

FRAUD WARNING

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.

SPECIAL PROVISIONS FOR EMPLOYERS WITH SECTION 125 PLANS

By allowing an individual to enroll in the Insurance Plan other thatn during the open enrollment period, CIGNA HealthCare or Connecticut General Life Insurace Company does not waive any terms of its contract. Further, by allowing an individual to enroll in the Insurance Plan other than during an open enrollment period, CIGNA HealthCare or Connecticut General Life Insurance Company does not thereby express any optinion regarding the appropriateness of the change under Section 125 of the Internal Revenue Code of the terms of the employer’s Section 125 Plan.