ARCHDIOCESE OF NEW YORK

Cigna

For More Information, Please Visit
www.mycigna.com

CIGNA DENTAL ENROLLMENT & CHANGE FORM

***NOTE**: Return your completed form to your Local Benefits Administrator within 30 calendar days of the date of enrollment, a life event, date of any change(s). Failure to do so may result in a loss of coverage.*

Reason for Completing This Form: ☐ Open Enrollment ☐ New Enrollment ☐ Status Change ☐ Reinstatement ☐ Address Change
☐ Dependent Enrollment ☐ Marital/Dependent Change Status ☐ Qualified Life Event _____

Effective Date: _____/_____/_____

Type of Change:

☐ Add Dependent(s) Effective Date _____/_____/_____ ☐ Waive Coverage
☐ Marital Status Change Effective Date _____/_____/_____
☐ Cancel Employee Effective Date _____/_____/_____
☐ Cancel Dependent(s) Effective Date _____/_____/_____

Member Information:

Last Name_____ First Name_____ MI____ Social Security No._____

Date of Birth_____/_____/_____ Gender ☐ Male ☐ Female Home Address_____ Apt. No._____

City_____ State_____ Zip_____ Home Phone_____ Email Address_____

Date of Hire____/____/_____ Occupation_____ Covered by Collective Bargaining Agreement: ☐ Yes ☐ No

Marital Status: ☐ Single ☐ Married (Marriage Date) ____/____/____ ☐ Divorced ☐ Widowed

☐ I am a Full Time Employee Scheduled to regularly work 30 or more hours per week *(20 hours for Bargaining Lay Faculty Members)* & participate in the medical health plan

Employer Information:

Employer (*Institution/Group*) _____ Inst./Dept. #_____/_____ Claims Division Code _____

Employer Street Address_____ City_____

State_____ Zip_____ Telephone _____

CIGNA Dental Plan: CIGNA Preferred Provider Organization (PPO)

Type of Election for the 2022 Plan Year & *Annual Costs*: ☐ Single $474.88 ☐ Two Person $995.87 ☐ Family $1,610.93 ☐ Waive Coverage

Dependent Information

List below your name and the name(s) of eligible dependents(s) to be covered, your spouse and dependent children. A child will be considered a dependent to the end of the month in which they turn age 26 as long as he/she is unmarried, and cannot be insured by or eligible for dental insurance through his/her own employer.

Name of Dependent	Sex *(M/F)*	Relationship To Employee	Date of Birth *Mo./Day/Yr.*	Social Security #

Employee Affirmation:

My signature below affirms eligibility for dental coverage and authorization to deduct elected contribution from my paycheck. All information is complete and true to the best of my knowledge.

Employee/Participant Signature *(Required)*: _____ Date: _____/_____/_____

Employee/Participant Print Name *(Required):* _____

Employer's Signature *(Required)*: _____ Date: _____/_____/_____

Employer Print Name *(Required)*: _____

Note: Any person who knowingly and with intent to defraud, submit an application for dental benefits or statement of claim containing any materially false information or conceals for the purpose of misleading information concerning any fact material thereto, commits a fraudulent act, which subject person to civil penalties.

Administrators: Please send completed form to Employees Benefit Connections at ebc@archny.org– for any questions or further assistance, please call 1.646.794.3060.

Administrators: *If you are a Regional Employee, your completed form must be send to your HR Coordinator.*