ARCHDIOCESE of NEW YORK

Cigna.

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 **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 _____/_____/_____	
☐ Leave Employment	Last Date of Coverage_____/_____/_____	

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**_____ **Work Phone**_____

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./Group No**._____ **Claim Division Code** _____

Employer Street Address_____ **City**_____

State_____ **Zip**_____ **Telephone** _____

CIGNA Dental Plan: CIGNA Preferred Provider Organization (PPO)

Type of Election for the 2018 Plan Year & *Annual Costs*: ☐ Single **$508.57** ☐ Two Person **$1,066.50** ☐ Family **$1,725.08**
(Type of Election Must Mirror Health Plan Election)

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 an application 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: Send completed form to Employees Benefit Connections at ebc@archny.org or fax to EBC 1.212.644.0690

Administrators - Contact Employee Benefit Connections at 1.646.794.3060 for further assistance.