Primary Applicant Name_____
Enrollment Form ID_____

Cigna

Connecticut General Life Insurance Company ('Cigna')

Colorado Individual and Family Plan Enrollment Application / Change Form

Section A. Type of Application

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

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:
☐ Colorado Open Access Plans: ☐ 1,000/80% ☐ 2,000/80% ☐ 3,000/80% ☐ 5,000/80% ☐ 5,000/100% ☐ 7,500/100% ☐ 10,000/100%
☐ Colorado Open Access Value Plans: ☐ 1,500/70% ☐ 2,500/70% ☐ 3,000/70% ☐ 5,000/70% ☐ 7,500/70% ☐ 10,000/70% ☐ 5,000/100%
☐ Colorado Open Access Value Plans: ☐ 1,500A/70% ☐ 2,500A/70% ☐ 3,000A/70% ☐ 5,000A/70% ☐ 7,500A/70% ☐ 5,000A/100%
☐ Colorado Health Savings Plans: ☐ 1,500 ☐ 3,000 ☐ 5,000
☐ Dental

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.)	Open Access Plan Primary Care Physician ID Number Optional _____ Current Patient: ☐ Yes ☐ No
Mailing Address – Home Address Required : _____ Street _____ City State _____ ZIP Code		Billing Address – If different than mailing address: _____ P.O. Box / Street _____ City State _____ ZIP Code				County:	Home Phone Number: ( ) _____-_____ Cell Phone Number: ( ) _____-_____ Work Phone Number: ( ) _____-_____ Email Address:
Spouse's Last Name:		First Name:				M.I.	Social Security Number:
Date of Birth:	Age:	☐ Single ☐ Married	☐ Male ☐ Female	Height: Ft.	In.	Weight: (Lbs.)	Open Access Plan Primary Care Physician ID Number Optional _____ 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.							
Dependent's Last Name:		First Name:				M.I.	Social Security Number:
Date of Birth:	Age:	☐ Single ☐ Married	☐ Male ☐ Female	Height: Ft.	In.	Weight: (Lbs.)	Open Access Plan Primary Care Physician ID Number Optional _____ Current Patient: ☐ Yes ☐ No
Dependent's Last Name:		First Name:				M.I.	Social Security Number

Primary Applicant Name_____ Enrollment Form ID_____

Date of Birth:	Age:	☐ Single ☐ Married	☐ Male ☐ Female	Height: Ft. In.	Weight: (Lbs.)	Open Access Plan Primary Care Physician ID Number Optional _____ 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. Current Coverage and Additional Prior Coverage Information

- You normally do not require more than one policy.
- If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverages.
- You may be eligible for benefits under Medicaid or Medicare and may not need an accident and sickness policy. If you are eligible for Medicare, you may want to purchase a Medicare Supplemental policy.
- If you are eligible for Medicare due to age or disability, counseling services may be available in your state to provide advice concerning your purchase of Medicare Supplement insurance and concerning medical assistance through the state Medicaid program.

D1. Does any applicant(s) have current health care coverage? ☐ Yes ☐ No

D2. If you answered "yes" to question D1, is the health care coverage similar to the Individual and Family Plan coverage from Cigna? ☐ Yes ☐ No

D3. If applicable, do you intend to replace your current accident and sickness insurance with this policy? ☐ Yes ☐ No

D4. If you do not have current health care coverage, have you had such coverage in the last 90 days? ☐ Yes ☐ No

D5. Are you covered for medical assistance through the state Medicaid program? ☐ Yes ☐ No
- a) As a Specified Low Income Medicare Beneficiary (SLMB)? ☐ Yes ☐ No
- b) As a Qualified Medicare Beneficiary (QMB)? ☐ Yes ☐ No
- c) For other Medicaid medical benefits? ☐ Yes ☐ No

If you answered "Yes" for any applicant to any of the above questions, please provide the following information for all health plan coverage the applicant has had for a total coverage period of 12 months, without a break in coverage at any time of more than 90 days:

Name of prior or current health plan carrier: _____ Type of Policy: _____

Applicants covered: _____

Coverage Start Date: _____ Coverage End Date (if applicable): _____

If applicant still has coverage, the date the policy paid through: _____

D6. 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: _____

D7. Is any applicant applying for coverage eligible for Medicare? ☐ Yes ☐ No If "Yes", provide:

Applicant Name: _____

D8. 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): _____

D9. 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
Loss of consciousness, fainting, dizziness	☐	☐
Numbness, tingling, weakness, paralysis, hemiplegia	☐	☐
Confusion, memory loss, Alzheimer's disease, dementia	☐	☐
Head injury, stroke	☐	☐
Migraine headaches, chronic severe headaches	☐	☐
Narcolepsy, sleep apnea or used a sleep monitoring device	☐	☐
Tremors, seizures/epilepsy, multiple sclerosis, muscular dystrophy, Parkinson's disease, cerebral palsy	☐	☐

	YES	NO
Reflex Sympathetic Dystrophy (RSD), Depression, anxiety, attention deficit, chemical imbalance	☐	☐
Bi-polar, obsessive-compulsive, panic disorders, psychosis, schizophrenia	☐	☐
Suicide attempt	☐	☐
Eating disorders, anorexia/bulimia	☐	☐
Attention deficit hyperactivity disorder (ADHD)/hyperactivity, autism, developmental delay	☐	☐
Alcohol or chemical dependence, substance abuse	☐	☐
Psychotherapy, counseling or support group	☐	☐

E2. Eyes, Ears, Nose, Throat	YES	NO
Eyes/sight: glaucoma, cataracts, crossed eyes, detached retina, corneal transplant, infections, retinopathy	☐	☐
Ears/Hearing: loss of hearing, deafness, infections, Eustachian tube dysfunction, acoustic neuroma	☐	☐
Nose/breathing: deviated septum, polyps, adenoiditis, sinustitis	☐	☐
Throat/swallowing: tonsillitis, strep throat, excessive snoring, sleep apnea	☐	☐

E3. Heart/Circulatory	YES	NO
Anemia, bleeding/clotting disorders, hemophilia, stroke, TIA	☐	☐
Varicose/spider veins, Raynauds, phlebitis, thrombosis	☐	☐
Enlarged lymph nodes or lymphadenitis	☐	☐
Chest pain, angina, congestive heart disease/failure, coronary artery disease	☐	☐
Heart attack, bypass surgery/angioplasty, valve disease/replacement, pacemaker/defibrillator	☐	☐
High/low blood pressure, hypertension, high cholesterol/lipids	☐	☐
Heart murmur, irregular heartbeat, palpitations	☐	☐
Aneurysm, rheumatic fever	☐	☐

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?	☐	☐

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	☐	☐

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?	☐	☐

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	☐	☐

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	☐	☐

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)	☐	☐

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	☐	☐

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	☐	☐

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	☐	☐

Primary Applicant Name_____ Enrollment Form ID_____

E13. Female Reproduction	YES	NO		YES	NO
a) Pelvic pain, abnormal menstrual bleeding, absence of menstruation, abnormal Pap smear	☐	☐	**b)** Has any applicant undergone infertility/fertility testing or received assisted reproductive therapy?	☐	☐
Endometriosis, ovarian cysts, uterine fibroids, miscarriage	☐	☐	If "Yes," provide complete detail in Section G.		
Breast cyst/lump/fibroids, breast implants	☐	☐	**c)** Has it been more than 40 days since any female listed on this application's last menstrual period?	☐	☐
Genital warts/herpes, sexually transmitted diseases	☐	☐	If "Yes," provide name:_____		
			Reason/Explain:_____		
d) Is any female applicant currently pregnant, tested positive with a home pregnancy test, or in the process of adoption or becoming a surrogate?	☐	☐	**e)** Has any female applicant had an abnormal Pap smear?	☐	☐
If "Yes," provide name:_____			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 result?	☐	☐
			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
All questions must be answered and complete details provided to all "Yes" answers for Sections F in Section G.		
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 ☐ Other Name:_____ ☐ Medical Condition ☐ DUI/DWI ☐ Prescribed Medication ☐ Other	☐	☐
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 been diagnosed as having or received treatment by a physician or health care provider for AIDS (Acquired Immune Deficiency Syndrome), diseases associated with AIDS, or other immune system disorders, or ever 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 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?	☐	☐
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?	☐	☐
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?	☐	☐
F16. Has any applicant ever received or been recommended to have follow up or future diagnostic testing?	☐	☐
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: Electronic Funds Transfer - EFT (Automatic draft from a checking or savings account) and Credit Card are the only initial payment methods allowed for online or faxed applications. The accounts will be charged only upon approval of your Application.

Electronic Funds Transfer – EFT (Automatic draft from a checking or savings account)

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

☐ Yes, I am requesting EFT for my initial payment. I agree that I am responsible for initiating all subsequent electronic monthly payments. I am requesting monthly electronic bills (eBills) to be sent to my email account as provided in section C of this application.

Account Number:_____ ☐ Checking ☐ Saving

Routing Number: ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

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

I authorize the Company (Cigna) 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 healthcare 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 care 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 the underwriting process will automatically be charged to your account. Please be advised that the premium adjustment may reflect an increase of 200% 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 the underwriting process will automatically be charged to your account.
Please be advised that the premium adjustment may reflect an increase of 200% of the standard rate.

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

Ongoing Payment Options if paying by paper check or credit card for initial payment (please select one option only)

☐ **Quarterly Paper Bill:** Yes, I am submitting a paper check (or have selected the credit card option) for my initial payment. I will submit a check for my ongoing quarterly payments. (monthly billing option is not available for this ongoing payment method).

☐ **EFT Draft:** Yes, I am submitting a paper check for my initial payment (or have selected the credit card option) and I am requesting recurring automatic EFT drafts for ongoing monthly payments. (No paper or electronic monthly or quarterly billing statements will be issued.) ***Please complete the EFT section above.***

☐ **Monthly Electronic Bill (eBill):** Yes, I am submitting a paper check (or have selected the credit card option) for my initial payment and agree that I am responsible for initiating all subsequent electronic monthly payments. I am requesting monthly electronic bills (eBills) to be sent to my email account provided in section C of this application.

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

☐ **EFT Draft:** Yes, I agree to recurring automatic EFT drafts for my ongoing monthly payments. (No paper or electronic monthly billing statement will be issued.) Please complete the EFT section above.

☐ **Monthly Electronic Bill (eBill):** Yes, I agree that I am responsible for initiating my ongoing electronic monthly payments. I am requesting monthly electronic bills (eBills) to be sent to my email account as provided in section C of this application.

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?		☐ 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:		
Producer shall list any other accident and sickness insurance that they have sold to the applicant.		
1. List policies sold which are still in force:_____		
2. List policies sold in the past five (5) years which are no longer in force: _____		
Cigna Sales Representative Last Name:		First Name:

Section P. Notice to Applicant Regarding Replacement of Accident and Sickness Insurance

Cigna
P.O. Box 30362
Tampa, FL 33630-3362

According to the information furnished by you, you intend to lapse or otherwise terminate your present policy and replace it with a policy to be issued by Cigna. Your new policy will provide 10 days within which you may decide without cost whether you desire to keep the policy.

You should review this new coverage carefully. Compare it with all accident and sickness coverage you now have. If, after due consideration, you find the purchase of this accident and sickness coverage is a wise decision you should evaluate the need for other accident and sickness coverage you have that may duplicate this policy.

Statement to Applicant By Issuer or Producer

I have reviewed your current accident and sickness insurance coverage. To the best of my knowledge, this accident and sickness policy will not duplicate your existing coverage because you intend to terminate your existing coverage. The replacement policy is being purchased for the following reason(s) (check one):

☐ Additional benefits

☐ No change in benefits, but lower premiums

☐ Fewer benefits and lower premiums

☐ Other, (please specify):_____

1. Health conditions which you may presently have (pre-existing conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay of claim for benefits under the new policy, whereas a similar claim may have been payable under your present policy.
2. State law provides that your replacement policy or contract may not contain new pre-existing conditions, waiting periods, elimination periods or probationary periods. The issuer will waive any time periods applicable to pre-existing conditions, waiting periods, elimination periods, or probationary periods in the new policy (or coverage) for similar benefits to the extent such time was spent (depleted) under the original policy.
3. If, you wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical and health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy has never been in force. After the application has been completed and before you sign it, review it carefully to be certain that all information has been properly recorded.

Do not cancel your present policy until you have received your new policy and are sure that you want to keep it.

Producer or Other Representative Signature:*_____ Date;_____

Print Name and Address of Issuer or Producer:_____

Applicant Signature:_____ Date:_____

**Signature not required for direct response sales.*

Section Q. Determination for Small Group Employer premium reimbursement for Small Group Employee

1. Will an employer of fifty (50) or fewer eligible employees be paying for or reimbursing an employee through wage adjustment, a health reimbursement arrangement or otherwise for any portion of the premium on the policy being applied for? If you answered "yes", please continue. If you answered "no", you may stop.	☐ Yes ☐ No
2. Did the employer have a small group health benefit plan providing coverage to any employee in the twelve months prior to the date of this application?	☐ Yes ☐ No

3. If the answer to question 1 is "yes" and the answer to question 2 is "no", the applicant must submit a signed affidavit from the employer certifying that the employer has not had a small group health benefit plan providing coverage to any employee in the previous twelve (12) months. The affidavit form to be executed by the employer is attached.
   If the answer to both questions 1 and 2 is "yes", the applicant may not be issued an individual policy with the premiums, or portion thereof, paid or reimbursed by the employer.

Affidavit

Employer's Name:_____

Employer's Address:_____

The undersigned officer or principal of the employer identified above certifies that:

1. The employer is a small employer as defined in § 10-16-102(40), C.R.S., with fifty (50) or fewer eligible employees;
2. The employer has not had in place a small group health benefit plan for the twelve (12) months prior to the execution of this affidavit.
3. A false certification may cause the rescission of the employee's individual insurance policy and subject the employer to penalties for perjury and liability to the employee.

Signed: _____

Printed Name: _____

Position: _____ Date: _____

Section R. Determination of Self-employed Business Group of One	
1. Are you either a self-employed person with no employees, or a sole proprietor who is not offering or sponsoring health care coverage to your employees?	Self ☐ Yes ☐ No Spouse ☐ Yes ☐ No
2. Have you carried on significant business activity as a self-employed person or sole proprietor for a period of at least one year prior to application for coverage?	Self ☐ Yes ☐ No Spouse ☐ Yes ☐ No
3. Do you have gross income from your self-employment or sole proprietorship as indicated on Federal Internal Revenue forms 1040, Schedule C, F, or SE, or other forms recognized by the Federal Internal Revenue Service for income reporting purposes from which you have derived a substantial part of your income from your business as a self-employed person or sole proprietor for one year out of the past three years? **NOTE:** Substantial part of your income means income derived from business activities of the business group of one that are sufficient to pay for the annual premiums for the business group of one's health benefit plan.	Self ☐ Yes ☐ No Spouse ☐ Yes ☐ No
4. Do you work a minimum of 24 hours a week on a permanent basis?	Self ☐ Yes ☐ No Spouse ☐ Yes ☐ No

I, (print name of applicant) _____, attest that the answers to the questions contained in this form are true and correct.
Signature of Applicant:_____ Date:_____
Applicant's Business:_____

I, (print name of applicant)_____, **meet the definition of a self- employed business group of one** as attested to in the **Determination of Self-employed Business Group of One**, Section Q of this application. I understand that by purchasing an individual policy instead of a small group policy, I give up what would otherwise be my right to purchase, during open enrollment periods as specified by law, a business group of one Standard, Basic, or other small group health benefit plan from a small group employer carrier for a period of three (3) years after the effective date of the individual health benefit plan for which I am applying. I understand that this will be the case unless a small group employer carrier voluntarily permits me to purchase a small group policy within such three (3) year period. I understand that the factors used to set new and renewal rates for the individual policy I want to purchase consist of plan design, my age, my gender, my health status, and that of my dependents, my family composition, the carrier's overall cost and utilization trends, the underwriting methodology used to evaluate individual coverage, tobacco use, Medicare eligibility, commissions paid to brokers, and a factor that reflects the cost of care where I live. By comparison, the rating factors that would apply if I purchased a small group business group of one policy are limited to plan design, the carrier's overall cost and utilization trends ('index rate'), my age, my family size, a factor that reflects the cost of care where I live, health status, claims experience, standard industrial classification and/or tobacco use. I have been given a health plan description form showing the benefits under Colorado's small group Standard Health Benefit Plans. I have been given a Colorado Health Plan Description Form for the plan for which I am applying.

Section S. 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 underwriting team within 30 days from the signature date.
- Any fraudulent 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. Do not cancel your current coverage until you have received notification from Cigna.
- 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 T. Conditions and Agreement/Authorization

1. I understand that any person who knowingly and with intent to injure, defraud , or deceive any insurer, files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

2. 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.

3. 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.

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

If a social security number is not provided on this application, Cigna will issue a Cigna assigned identification number to identify our plan members. Risks associated with the use of an assigned identification number include the following: 1) the possibility exists that the assigned identification number may match another individual's Social Security number or an assigned identification number issued by another company; and 2) use of an assigned identification number does not eliminate the possibility that another individual will access or misuse information related to that number.

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.

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 12 months before an individual's enrollment effective date under the contract. 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 fraudulent 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 U. Contact Information

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

Cigna Individual and Family Plans

P.O. Box 30362

Tampa, FL 33630-3362

FAX # 877.484.5927

www.Cigna.com

Section V. Authorization to Release Information to Cigna for Pre-Enrollment Processing

TO APPLICANT FOR HEALTH INSURANCE 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 HIV, Acquired Immune Deficiency Syndrome (AIDS) or other related syndromes or complexes, communicable diseases or disorders or sexually transmitted diseases; 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 health insurer, health maintenance organization, or other health insurance issuer; any licensed physician, medical practitioner, clinic or other medical or medically related facility; or any other person or organization possessing the information described above.

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: Thirty (30) 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 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 understand that I or my Personal Representative has the right to receive a copy of this Authorization.

All applicants 18 years and older must sign and date application.			
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)	Dependent Applicant Age 18 or Older:	Today's Date: (MM/DD/YYYY)