New Jersey Small Employer Health Benefits Plan
Enrollment Change Form

Subscriber: Complete Sections A, B and C; Then Sign and Date Section D

CIGNA HealthCare of New Jersey, Inc.
P.O. Box 2010
Concord, NH 03302
Fax #: 603-229-2980

SECTION A: ELIGIBLE PERSONS TO BE ENROLLED ***(Note: Dependent children may be covered under their parent's contract only while unmarried and until they reach age 19 or 23, if full-time students. Unmarried, mentally and physically handicapped dependent children can continue beyond the age limits above as long as they remain incapacitated and unmarried.)***

Applicant *(Last, First, M.I.)*	Home Telephone ( )	Business Telephone ( )	Best Place to Call During Day: ☐ Home ☐ Work

Are you actively at work? ☐ Yes ☐ No	If "No", explain:

Primary Residence Address *(no.) (street) (apt.) (city) (state) (zip)*	County	CN

Are you a resident of the State of New Jersey? ☐ Yes ☐ No	Do you maintain a residency in any other state? ☐ Yes ☐ No	If "Yes", (a) Name of state	(b) How much time do you spend there each year?

	This section must be completed in its entirety. Last Name First Middle Initial	Birthdate Mo. Day Yr.	Sex	Social Security Number	Choose Primary Care Physician or Health Care Center for Each Person	Primary Office Number
01	Applicant ☐ Add ☐ Remove		☐ M ☐ F			
02	Spouse ☐ Add ☐ Remove		☐ M ☐ F			
03	Child ☐ Add ☐ Remove Relationship		☐ M ☐ F			
04	Child ☐ Add ☐ Remove Relationship		☐ M ☐ F			
05	Child ☐ Add ☐ Remove Relationship		☐ M ☐ F			

Attach sheet to list additional children. Attach proof if full-time student. Attach proof of disability.

Do any of the dependents listed in Section A live at another address? ☐ Yes ☐ No	If yes, who and at what address?	Explain the circumstances	If any dependent's last name is different from yours, explain the circumstances

SECTION B: OTHER HEALTH CARE COVERAGE ***(Please note that, in some situations, if you are eligible for other health benefits coverage, you are not eligible for this policy.)***

Are you eligible for other health benefits coverage? (i.e., coverage under your employer's health benefits coverage, Medicare or Medicaid) ☐ Yes ☐ No	If Medicare, covered under: ☐ Part A ☐ Part B	If yes, give name and policy no. of other carrier or type of coverage	Are other family members eligible for coverage? If yes, specify:

Are you replacing existing coverage? ☐ Yes ☐ No	If yes, give name and policy no. of other carrier, initial effective date of coverage, date of termination, and specify those covered by policy

Have you or your dependents ever been a member of CIGNA HealthCare? ☐ Yes ☐ No	If yes, under what name and social security no.?	Where? CIGNA HealthCare of:	Covered as: ☐ Subscriber ☐ Dependent

SECTION C: PLEASE MARK TYPE OF ACTIVITY

Type of Activity:
- ☐ Refused/Waived Coverage Previously
- ☐ Withdrawal from Coverage - Date of Event: __________
- ☐ Continuing Coverage under State or Federal Law
- ☐ Other *(specify)*______________________
- ☐ Add/Remove Dependent Reason______________________ Date____________
- ☐ New Telephone Number (h) ______________________ (w) ______________________
- ☐ Change Contract Type From/To______________________
- ☐ Name Change From______________________ To______________________
- ☐ Change of Primary Care Physician

Check Reasons:
- ☐ Deceased
- ☐ Transferred to Other Coverage
- ☐ Dissatisfied with Benefits
- ☐ Ineligible
- ☐ Moved Out of Area
- ☐ Dissatisfied with Medical Care
- ☐ Dissatisfied with Access
- ☐ Other *(Please Explain)* ______________________

SECTION D: AUTHORIZATION AND CERTIFICATION

Which coverage have you selected to provide benefits under the Personal Injury Protection (PIP) segment of your New Jersey auto insurance?	☐ Auto ☐ Medical	Which coverage have you selected to be primary in the event that expenses are incurred as a result of an automobile-related injury?	☐ Auto ☐ Medical

I hereby apply to CIGNA HealthCare of New Jersey, Inc. for coverage for eligible dependents listed above and myself.

I understand that, by signing below when I file a claim, CIGNA HealthCare of New Jersey, Inc. may pay the health care benefits directly to the provider instead of to me.

I understand that after I enroll, CIGNA HealthCare may need to obtain Confidential Information. I also understand that CIGNA HealthCare may need to provide this Confidential Information to others. Any person or entity having Confidential Information has my permission to provide this Confidential Information upon request to CIGNA HealthCare, any CIGNA HealthCare participating provider, or any other provider or entity performing a service for the purpose of plan administration, the performance of any CIGNA HealthCare program or operations, or to assess the quality of and access to health care services and supplies. CIGNA HealthCare has my permission to give any Confidential Information to any person, company or entity when it determines that such disclosure is necessary or appropriate for the administration of the plan, the performance of CIGNA HealthCare programs or operations, assessing quality and accessibility of health care services and supplies, or reporting to third parties involved in plan administration. I am making this authorization for myself and as the agent or representative of my spouse and any dependent children. I understand that it will remain in effect until I send written notice revoking it to CIGNA HealthCare or for such shorter period as required by law. Until revoked, this authorization may be relied upon by CIGNA HealthCare and other parties. "Confidential Information" means, with respect to me and any covered dependents, any medical, dental, mental health, substance abuse, communicable disease, AIDS and HIV related information and disability or employment related information. CIGNA HealthCare means the CIGNA companies involved in the administration of the plan.

Note: Any person who knowingly files a statement of claim, application for insurance, Enrollment Application and Change Form, containing any false or misleading information may be subject to criminal and civil penalties.

Applicant's Signature	Date Signed

SECTION E: FOR EMPLOYER'S USE ONLY

Company's Name	Date of Hire	Group Number	Effective Date
Benefits Administrator's Signature	Date	Reason for Application ☐ New Hire ☐ Change ☐ COBRA ☐ Open Enrollment ☐ Other	

HEALTH MAINTENANCE ORGANIZATION (HMO) ENROLLMENT APPLICATION (AND CHANGE FORM) SMALL EMPLOYER HEALTH BENEFITS PLAN FOR EMPLOYEES AND DEPENDENTS

CONDITIONS OF ACCEPTANCE

On behalf of myself and the dependents listed on the reverse side, I agree to or with the following:

1. Coverage of applicant and of the listed dependents shall depend on acceptance by CIGNA HealthCare after a review of the application and receipt of payment.
2. Applicant is applying for individual coverage for the applicant, applicant's spouse and any eligible unmarried children under nineteen (19) years of age, unmarried children who are mentally or physically incapacitated and who are chiefly dependent upon the applicant or the applicant's spouse for support and maintenance or are unmarried children between the ages of nineteen (19) and twenty-three (23) who are full-time students at an accredited educational institution.
3. Coverage and benefits are contingent on timely payment of premiums and may be terminated as provided in the Contract.
4. The contract will determine the rights and responsibilities of member(s) and subscriber(s) and will govern in the event it conflicts with any benefits comparison, summary or other description of the health benefits plan.
5. As a condition to benefits, applicant understands and agrees that with the exception of emergency procedures as defined in the Contract all services, in order to be covered by CIGNA HealthCare, must be performed either by a participating primary care physician or by the participating specialist, hospital or other provider as authorized by prior written referral from the participating primary care physician.
6. Applicant agrees to make payment directly to health care providers such copayments as are provided for in the employer's health benefits plan.
7. Applicant understands that this coverage will remain in effect regardless of the continued availability of a particular primary care physician or other health care provider.
8. Applicant acknowledges that CIGNA HealthCare's participating providers, including all participating primary care physicians, are independent contractors and are not agents or employees of CIGNA HealthCare.
9. No person, except an officer of CIGNA HealthCare, has authority to: determine whether any certification shall be issued on the basis of this Enrollment Application and Change Form; waive or modify any of the provisions of the Enrollment Application and Change Form; or any of the requirements to bind by any statement or promise pertaining to any certificate signed or to be issued on the basis of this Enrollment Application and Change Form; or accept any information or representation not continued in the written Enrollment Application and Change Form.
10. I agree that: (a) any physician, hospital or other provider is authorized to provide to CIGNA HealthCare or assignee information about any eligible person's history; and (b) any company or person having information concerning other health care coverage in force, or available to, any eligible person may give such information to CIGNA HealthCare or assignee.
11. I state that: (a) I am a resident of New Jersey and I reside within the CIGNA HealthCare service area (b) the information given on this application is complete to the best of my knowledge and belief and (c) that CIGNA HealthCare will rely on this information to determine eligibility. I understand that if I omit or falsify any statement in this application CIGNA HealthCare can cancel my coverage as of the original effective date.
12. CIGNA HealthCare does not pay benefits for charges, or provide services or supplies related to a pre-existing condition for 180 days, measured from the enrollment date. I understand that a Pre-Existing Condition is an Illness or Injury which manifests itself in the six months before a person's Enrollment Date, and for which medical advice, diagnosis, care or treatment was recommended or received during the six months immediately preceding the Enrollment Date. I also understand that New Jersey law only permits the application of the pre-existing conditions limitation under certain circumstances and that I or my dependents will only be subject to this limitation to the extent permitted by New Jersey law.

Note to all applicants: If we accept your application, a copy of the application will be sent to you. Attach the copy of your evidence of coverage. It becomes part of your evidence of coverage.