CIGNA ENROLLMENT / CHANGE FORM

Group Number: *3211196*	**Effective Date: 0 7 / 0 1 / 2 0 2 4** *(Return form to Heather Orosz, Benefits Office by May 31,2024)*
Employer Name: *Simsbury Public Schools*	**Employer Address:** *933 Hopmeadow St, Simsbury, CT 06070*
Employee Branch/Division/Class: *NURSE - Nurses*	

Choose Plan Type: *(Choose only one)*

Open Access Plus - OAP (PPO)	In-Network Only Open Access Plus – OAP-IN (HMO)	High Deductible Health Plan with Health Savings Account – HDHP/HSA	High Deductible Health Plan with Health Reimbursement Account – HDHP/HRA
☐	☐	☐	☐

(Please Print)

EMPLOYEE LAST NAME:	*EMPLOYEE FIRST NAME:*	*MI*	*SOCIAL SECURITY NUMBER*

EMPLOYEE DATE OF BIRTH *(MM-DD-YYYY)*	*HOME PHONE*	*WORK PHONE*	*HOME E-MAIL ADDRESS*	*EMPLOYEE ID NUMBER*
	( )	*( )*		

STREET ADDRESS:	*CITY*	*STATE*	*ZIP CODE*

I WOULD LIKE COVERAGE FOR ME AND MY DEPENDENTS

(Specify last name if different from yours)

LAST NAME, FIRST NAME, MI	SOCIAL SECURITY NUMBER *(Required)*	DATE OF BIRTH *(MM-DD-YYYY)*	GENDER
Employee			
Spouse			
*Dependent**			
*Dependent**			
*Dependent**			
*Dependent**			

EMPLOYEE'S SIGNATURE / DATE	EMPLOYER'S SIGNATURE / DATE

**Dependents – Dependents are covered under the medical plan up to age 26. If totally disabled prior to dependent eligibility end date, attach proof of disability for eligibility review.*