

## CIGNA ENROLLMENT / CHANGE FORM

<b>Group Number:</b> 3211196	<b>Effective Date:</b> 07/01/2024 <small>(Return form to Heather Orosz, Benefits Office by May 31,2024)</small>
<b>Employer Name:</b> Simsbury Public Schools	<b>Employer Address:</b> 933 Hopmeadow St, Simsbury, CT 06070
<b>Employee Branch/Division/Class:</b> UNAFF – Unaffiliated / Nutrition Svcs / SEED / DCE	

**Choose Plan Type:** *(Choose only one)*

<b>Open Access Plus - OAP (PPO)</b>  <input type="checkbox"/>	<b>In-Network Only Open Access Plus – OAP-IN (HMO)</b>  <input type="checkbox"/>	<b>High Deductible Health Plan with Health Savings Account – HDHP/HSA</b>  <input type="checkbox"/>	<b>High Deductible Health Plan with Health Reimbursement Account – HDHP/HRA</b>  <input type="checkbox"/>
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*(Please Print)*

<b>EMPLOYEE LAST NAME:</b>		<b>EMPLOYEE FIRST NAME:</b>		<b>MI</b>	<b>SOCIAL SECURITY NUMBER</b>
<b>EMPLOYEE DATE OF BIRTH</b> <small>(MM-DD-YYYY)</small>	<b>HOME PHONE</b> <small>(     )</small>	<b>WORK PHONE</b> <small>(     )</small>	<b>HOME E-MAIL ADDRESS</b>		<b>EMPLOYEE ID NUMBER</b>
<b>STREET ADDRESS:</b>		<b>CITY</b>	<b>STATE</b>	<b>ZIP CODE</b>	

**I WOULD LIKE COVERAGE FOR ME AND MY DEPENDENTS**

*(Specify last name if different from yours)*

<b>LAST NAME, FIRST NAME, MI</b>	<b>SOCIAL SECURITY NUMBER</b> <small>(Required)</small>	<b>DATE OF BIRTH</b> <small>(MM-DD-YYYY)</small>	<b>GENDER</b>
<i>Employee</i>			
<i>Spouse</i>			
<i>Dependent*</i>			
<i>Dependent*</i>			
<i>Dependent*</i>			
<i>Dependent*</i>			
<b>EMPLOYEE'S SIGNATURE / DATE</b>	<b>EMPLOYER'S SIGNATURE / DATE</b>		

\*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.