

CIGNA ENROLLMENT / CHANGE FORM

Group Number: 3211196	Effective Date: 07/01/2024 <small>(Return form to Heather Orosz, Benefits Office by 05/31/2024)</small>
Employer Name: Simsbury Public Schools	Employer Address: 933 Hopmeadow St, Simsbury, CT 06070
Employee Branch/Division/Class: SEA - Teachers	

Choose Plan Type: *(Choose only one)*

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

EMPLOYEE LAST NAME:		EMPLOYEE FIRST NAME:		MI	SOCIAL SECURITY NUMBER
EMPLOYEE DATE OF BIRTH <small>(MM-DD-YYYY)</small>	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 <small>(Required)</small>	DATE OF BIRTH <small>(MM-DD-YYYY)</small>	GENDER
<i>Employee</i>			
<i>Spouse</i>			
<i>Dependent*</i>			
<i>Dependent*</i>			
<i>Dependent*</i>			
<i>Dependent*</i>			
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.