|  |
| --- |
| **CIGNA ENROLLMENT / CHANGE FORM** |
| **Group Number:** *3211196* | **Effective Date: *07/01/2023****(Return form to Heather Orosz, Benefits Office by May 31,2023)* |
| **Employer Name:** *Simsbury Public Schools* | **Employer Address:** *933 Hopmeadow St, Simsbury, CT 06070* |
| **Employee Branch/Division/Class:** *SFEP – Clerical / Paraeducators* |
| **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.* |
| *Filename: Cigna Enrollment Change Form 2023– SFEP.docx* |