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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **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* | | | | | | | | | | | | |