Primary Applicant Name_____
Application Form ID_____

Cigna Health and Life Insurance Company
Colorado Application for Dental Insurance

Section A. Dental Coverage Options:

1. Select who the coverage is for:
☐ Primary Applicant Only ☐ Primary Applicant and Dependent(s) ☐ Child(ren) Only

2. Select what coverage applicant(s) is/are applying for:
☐ New Dental Coverage ☐ Add Family Member(s) to existing dental policy ☐ Add dental coverage to existing medical policy
☐ Request Plan Change ☐ Reinstatement

Policyholder's Name: _____ ID Number: _____

3. Select Requested Effective Date:*
☐ 1st of the Month of_____
*Next available effective date will be assigned if not selected by the applicant.

Section B. Benefit Plan Option:

☐ Cigna Dental Preventive
☐ Cigna Dental 1000
☐ Cigna Dental 1500

Section C. Applicant(s) applying for coverage: Dependent children are eligible for coverage up to age 26.

Last Name	First Name	M.I.	Age	Date of Birth (MM/DD/YYYY)	Gender	Social Security Number
Primary Applicant					☐ Male ☐ Female	
Custodial Parent or Legal Guardian Name (for applicants under the age of 18):					Relationship to Applicant:	
Spouse/Domestic Partner/Civil Union					☐ Male ☐ Female	
Dependent 1					☐ Male ☐ Female	
Dependent 2					☐ Male ☐ Female	
Dependent 3					☐ Male ☐ Female	
Dependent 4					☐ Male ☐ Female	

☐ Check here if you are providing names of additional dependents on an attached separate page.

Section D. Primary Applicant's Information:

Home Address Required:

_____
Street

_____
City State ZIP Code

_____
Preferred Household Email Address*:

Mailing Address (if different than Home Address):

_____
Street

_____
City State ZIP Code

_____ _____ _____
Cell Phone Home Phone Work Phone

*By providing your e-mail address, you agree to receive electronic communications about your application status, enrollment and Cigna Health and Life Insurance Company health benefit plans, products and services.

Primary Applicant's marital status: ☐ Married ☐ Single

Section E. Prior / Current Coverage Information

E1. Do you have prior or current dental coverage? ☐ Yes ☐ No

E2. If any applicant answered "Yes" to the above question, please provide the following information:

Most recent dental coverage start date: (MM/DD/YYYY) _____ Termination date: (MM/DD/YYYY) _____

Name of prior or current dental plan carrier: _____ Policy Number: _____

Type of prior or current dental policy: ☐ Discount dental plan ☐ Preventive only dental plan ☐ Full coverage dental plan
☐ Other (please explain) _____

E3. Does this information apply to all family members on this application? ☐ Yes ☐ No

If "No", please add additional coverage information in the space provided below.

Applicant #1 Name: _____

Most recent dental coverage start date: (MM/DD/YYYY) _____ Termination date: (MM/DD/YYYY) _____

Name of prior or current dental plan carrier: _____ Policy Number: _____

Type of prior or current dental policy: ☐ Discount dental plan ☐ Preventive only dental plan ☐ Full coverage dental plan
☐ Other (please explain) _____

Applicant #2 Name: _____

Most recent dental coverage start date: (MM/DD/YYYY) _____ Termination date: (MM/DD/YYYY) _____

Name of prior or current dental plan carrier: _____ Policy Number: _____

Type of prior or current dental policy: ☐ Discount dental plan ☐ Preventive only dental plan ☐ Full coverage dental plan
☐ Other (please explain) _____

Applicant #3 Name: _____

Most recent dental coverage start date: (MM/DD/YYYY) _____ Termination date: (MM/DD/YYYY) _____

Name of prior or current dental plan carrier: _____ Policy Number: _____

Type of prior or current dental policy: ☐ Discount dental plan ☐ Preventive only dental plan ☐ Full coverage dental plan
☐ Other (please explain) _____

E4. Do you intend to replace your current dental insurance with this policy? ☐ Yes ☐ No

E5. Do you have current medical coverage? ☐ Yes ☐ No

Section F. Payment Method

NOTE: Electronic Funds Transfer - EFT (Automatic draft from a checking or savings account) and Credit Card is/are the only initial payment method(s) allowed for online or faxed applications. The accounts will be charged upon approval of your Application.

Please select your payment method from the below options:

Premium Payment Frequency:

☐ Monthly

Initial Premium Payment Method:

☐ Electronic Funds Transfer (EFT) ☐ Automatic Credit Card Payment ☐ Paper Check

Electronic Funds Transfer - EFT (Automatic draft from a checking or savings account)

☐ Yes, I am requesting EFT for both for my initial payment and for ongoing recurring monthly payments (no paper or electronic monthly billing statement will be issued).

☐ Yes, I am requesting EFT for my initial payment. I agree that I am responsible for initiating all subsequent electronic monthly payments. I am requesting monthly electronic bills (eBills) to be sent to my email account as provided in Section D of this application.

Account Number:_____ ☐ Checking ☐ Saving

Routing Number: ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

Name of Bank:_____ Name(s) on Account:_____

I authorize the Company (Cigna Health and Life Insurance Company) to make premium withdrawals, in the amount of the premium payment noted above, from my bank account as identified on this form and authorize the banking facility (Bank) to charge such withdrawals to my account. This authority will remain in effect until the Company receives written notice from me that the authority is terminated. Such termination will be effective with respect to the next premium due following 21 days after the written notice is received by the Company. I understand that if for any reason, a withdrawal is not honored by the Bank (including, but not limited to, insufficient funds or my direction to the Bank not to honor the withdrawal) my health care contract premium will be unpaid, and failure to pay my health care contract premium may result in termination for my health care contract, and that this authorization will remain in place until cancelled and that any due or past due premiums may be withdrawn under this authorization. I understand and agree that termination of this authorization does not relieve me of responsibility for charges incurred under my health care contract. I agree to indemnify and hold harmless the Company and its affiliates and employees for any claims arising out of transfers or deductions from my account in accordance with this authorization.

Credit Card

Name on Credit Card: _____ Expiration Date: _____

☐ VISA ☐ MASTERCARD

Card Number: ☐☐☐☐-☐☐☐☐ - ☐☐☐☐-☐☐☐☐

3-digit Code: _____ ZIP Code: _____

For Paper Application: ***Please check here:*** ☐ **Paper check is attached or** ☐ **Credit card information provided.**

Ongoing Payment Options if paying by paper check or credit card for initial payment (please select one option only)

☐ **Monthly Paper Bill:** Yes, I am submitting a paper check (or have selected the Credit Card option) for my initial payment. I will submit a check for my ongoing monthly payments.

☐ **EFT Draft:** Yes, I am submitting a paper check for my initial payment (or have selected the Credit Card option) and I am requesting recurring automatic EFT drafts for ongoing monthly payments. (No paper or electronic monthly or quarterly billing statements will be issued.) Please complete EFT Section.

☐ **Monthly Electronic Bill (eBill):** Yes, I am submitting a paper check (or have selected the Credit Card option) for my initial payment and agree that I am responsible for initiating all subsequent electronic monthly payments. I am requesting monthly electronic bills (eBills) to be sent to my email account provided in section C of this application.

☐ **Credit Card:** Yes, I agree to recurring automatic Credit Card drafts for my ongoing monthly payments. (No paper or electronic monthly billing statement will be issued.) Please complete the Credit Card section above.

For Online electronic submitted Application:

Ongoing Payment Options if Credit Card Option was selected for initial payment (please select one option only).

☐ **EFT Draft:** Yes, I agree to recurring automatic EFT drafts for my ongoing monthly payments. (No paper or electronic monthly billing statement will be issued.) Please complete the EFT section above.

☐ **Monthly Electronic Bill (eBill):** Yes, I agree that I am responsible for initiating my ongoing electronic monthly payments. I am requesting monthly electronic bills (eBills) to be sent to my email account as provided in section C of this application.

☐ **Credit Card:** Yes, I agree to recurring automatic Credit Card drafts for my ongoing monthly payments. (No paper or electronic monthly billing statement will be issued.) Please complete the Credit Card section above.

Section G. Statement of Accountability – *To be completed when applicant cannot complete this application.*

I, _____, personally read and completed this Application form for the Applicant named below because:

☐ Applicant does not read English ☐ Applicant does not speak English ☐ Applicant does not write English

☐ Other (explain):_____

I personally translated the contents of this application and, to the best of my knowledge, obtained and listed all the personal information disclosed by:

_____

I also personally translated and fully explained the "Conditions and Agreement/Authorization Section":

_____ _____

Signature of Translator *required*
(Excludes Parent Signature if Child Only Application)

Today's Date required

Section H. Producer Information

Writing Producer Name:	Producer Code:	
Street Address:	City:	State: ZIP Code:
Email Address:		
Phone Number:		
Are you aware of any information about your client not disclosed on this application? ☐ Yes ☐ No		
Did you see the proposed applicant at the time this application was completed? ☐ Yes ☐ No If "No", please explain:_____		
I verify that the application was completed by the applicant unless otherwise noted in the Statement of Accountability.		
Signature of Writing Producer:		Date: (MM/DD/YYYY)
Please enter the name of the Agency/Producer that checks are to be made payable to if different from Writing Producer:		Producer Code:
Street Address:	City:	State: ZIP Code:
Email Address:		
Phone Number:		
Sales Representative Last Name:		First Name:

Section I. Conditions and Agreement/Authorization

1. I understand that it is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete or misleading facts or information to a policyholder or claimaint for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.
2. I understand that I or my authorized representative is entitled to receive a copy of this authorization form.
3. I understand that information disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and will no longer be protected by federal privacy regulations.
4. If the applicant is a minor, I accept full legal and financial responsibility for the coverage and information provided on this application. (Court documents establishing guardianship must be submitted if the responsible adult is not the parent).

I acknowledge and agree that coverage shall become effective only after (a) this signed Application has been accepted by Cigna Health and Life Insurance Company, and (b) a contract has been issued by Cigna Health and Life Insurance Company.

I AGREE ON BEHALF OF MYSELF AND AS AUTHORIZED AGENT OR REPRESENTATIVE OF MY ELIGIBLE DEPENDENTS TO THE PROVISIONS CONTAINED ON THIS FORM, INCLUDING THE PROVISIONS REGARDING THE COLLECTION, USE, AND DISCLOSURE OF PROTECTED HEALTH INFORMATION.

All applicants 18 years and older must sign and date application. Applicants under the age of 18 require custodial parent or legal guardian signature acknowledging their understanding of and agreement to the conditions listed above.

The above statements are true and complete to the best of my knowledge and belief. I understand and agree that for my child, and/or me and my eligible dependents, these statements shall be the basis for determination of acceptance for coverage under my applicable Cigna Health and Life Insurance Company benefit plan. I acknowledge and agree that any misrepresentation or intentional omission may render this contract null and void from its date of issue in accordance with applicable law. If my coverage is revoked, I will receive written notice that will explain the decision and my right to appeal. I also understand that I will be required to pay for any services that were covered while a member and that Cigna Health and Life Insurance Company will refund all amounts paid by me except amounts owed to Cigna Health and Life Insurance Company.

You may be eligible for benefits under Medicaid or Medicare and may not need an accident and sickness policy. If you are eligible for Medicare, you may want to purchase a Medicare Supplemental policy.

Primary Applicant Signature:	Today's Date: (MM/DD/YYYY)
Custodial Parent or Legal Guardian Signature (for applicants under the age of 18):	Today's Date: (MM/DD/YYYY)

Section J. Instructions:

- **Mail or FAX this application to:**
  Cigna Health and Life Insurance Company Individual and Family Plans
  P.O. Box 30362
  Tampa, FL 33630-3362
  FAX: 1-877-484-5927
- Fill in all information and print clearly using black or blue ink.
- The applicant is responsible for ensuring that the application is complete and truthful.
- Coverage will become effective only if this application is approved.
- Coverage is not guaranteed until you receive written notification from Cigna Health and Life Insurance Company. Do not cancel your current coverage until you have received written notification from Cigna Health and Life Insurance Company.
- Requested Effective Date cannot be greater than 60 days after the signature date. No Effective Dates will be assigned prior to or on the signature date.
- If you have questions about completing this application, please call Cigna Health and Life Insurance Company at 1-866-GET-Cigna (1-866-438-2446)
  8 am - 8 pm ET, Monday - Friday

Section K. Notice to Applicant Regarding Replacement of Dental Insurance

1. Statements
   a. You normally do not require more than one of the same type of policy.
   b. If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverages.
   c. You may be eligible for benefits under Medicaid or Medicare and may not need an accident and sickness policy. If you are eligible for Medicare, you may want to purchase a Medicare Supplemental policy.
   d. If you are eligible for Medicare due to age or disability, counseling services are available in Colorado to provide advice concerning your purchase of Medicare supplement insurance and concerning medical assistance through the state Medicaid program.
2. Questions
   To the best of your knowledge:
   a. Do you have another insurance policy or contract in force? ☐ Yes ☐ No
      (1) If so, with which company? _____
      (2) If so, do you intend to replace your current accident and sickness insurance with this policy (contract)? ☐ Yes ☐ No
   b. Do you have any other accident and sickness insurance that provides benefits similar to this accident and sickness policy? ☐ Yes ☐ No
      (1) If so, with which company? _____
      (2) What kind of policy? _____
   c. Are you covered for medical assistance through the state Medicaid program:
      (1) As a Specified Low-Income Medicare Beneficiary (SLMB)? ☐ Yes ☐ No
      (2) As a Qualified Medicare Beneficiary (QMB)? ☐ Yes ☐ No
      (3) For other Medicaid medical benefits? ☐ Yes ☐ No

Producers must list any other accident and sickness insurance they have sold to the applicant.

1. List policies sold which are still in force: _____
2. List policies sold in the past five (5) years which are no longer in force: _____

NOTICE TO APPLICANT REGARDING REPLACEMENT OF A HEALTH BENEFIT PLAN

According to your application, you intend to lapse or otherwise terminate your present policy and replace it with a policy to be issued by Cigna Health and Life Insurance Company. Your new policy will provide 10 days of free look period, within which you may decide without cost whether you want to keep the policy.

You should review this new coverage carefully. Compare it with all accident and sickness coverage you now have. If, after due consideration, you find the purchase of this accident and sickness coverage is a wise decision you should evaluate the need for other accident and sickness coverage you have that may duplicate this policy.

STATEMENT TO APPLICANT BY CARRIER OR PRODUCER:

I have reviewed your current accident and sickness insurance coverage. To the best of my knowledge, this accident and sickness policy will not duplicate your existing coverage because you intend to terminate your existing coverage. The replacement policy is being purchased for the following reason(s) *(check one)*:

☐ Additional benefits

☐ No change in benefits, but lower premiums

☐ Fewer benefits and lower premiums

☐ Other (please specify): _____

Do not cancel your current policy until you have received your new policy and are sure that you want to keep it.

Signature of Producer or Other Representative	
Typed Name and Address of Carrier or Producer	
Applicant's Signature:	Today's Date: (MM/DD/YYYY)

DISCRIMINATION IS AGAINST THE LAW

Medical coverage

Cigna complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Cigna does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Cigna:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact customer service at the toll-free number shown on your ID card, and ask a Customer Service Associate for assistance.

If you believe that Cigna has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance by sending an email to ACAGrievance@Cigna.com or by writing to the following address:

Cigna
Nondiscrimination Complaint Coordinator
PO Box 188016
Chattanooga, TN 37422

If you need assistance filing a written grievance, please call the number on the back of your ID card or send an email to ACAGrievance@Cigna.com. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, DC 20201
1.800.368.1019, 800.537.7697 (TDD)
Complaint forms are available at
http://www.hhs.gov/ocr/office/file/index.html.

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Proficiency of Language Assistance Services

English – ATTENTION: Language assistance services, free of charge, are available to you. For current Cigna customers, call the number on the back of your ID card. Otherwise, call 1.800.244.6224 (TTY: Dial 711).

Spanish – ATENCIÓN: Hay servicios de asistencia de idiomas, sin cargo, a su disposición. Si es un cliente actual de Cigna, llame al número que figura en el reverso de su tarjeta de identificación. Si no lo es, llame al 1.800.244.6224 (los usuarios de TTY deben llamar al 711).

Chinese – 注意：我們可為您免費提供語言協助服務。對於 Cigna 的現有客戶，請致電您的 ID 卡背面的號碼。其他客戶請致電 1.800.244.6224 （聽障專線：請撥 711）。

Vietnamese – XIN LƯU Ý: Quý vị được cấp dịch vụ trợ giúp về ngôn ngữ miễn phí. Dành cho khách hàng hiện tại của Cigna, vui lòng gọi số ở mặt sau thẻ Hội viên. Các trường hợp khác xin gọi số 1.800.244.6224 (TTY: Quay số 711).

Korean – 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 현재 Cigna 가입자님들께서는 ID 카드 뒷면에 있는 전화번호로 연락해주십시오. 기타 다른 경우에는 1.800.244.6224 (TTY: 다이얼 711)번으로 전화해주십시오.

Tagalog – PAUNAWA: Makakakuha ka ng mga serbisyo sa tulong sa wika nang libre. Para sa mga kasalukuyang customer ng Cigna, tawagan ang numero sa likuran ng iyong ID card. O kaya, tumawag sa 1.800.244.6224 (TTY: I-dial ang 711).

Russian – ВНИМАНИЕ: вам могут предоставить бесплатные услуги перевода. Если вы уже участвуете в плане Cigna, позвоните по номеру, указанному на обратной стороне вашей идентификационной карточки участника плана. Если вы не являетесь участником одного из наших планов, позвоните по номеру 1.800.244.6224 (TTY: 711).

Arabic – برجاء الانتباه خدمات الترجمة المجانية متاحة لكم. لعملاء Cigna الحاليين برجاء الاتصال بالرقم المدون علي ظهر بطاقتكم الشخصية. او اتصل ب 1.800.244.6224 (TTY: اتصل ب 711).

French Creole – ATANSYON: Gen sèvis èd nan lang ki disponib gratis pou ou. Pou kliyan Cigna yo, rele nimewo ki dèyè kat ID ou. Sinon, rele nimewo 1.800.244.6224 (TTY: Rele 711).

French – ATTENTION: Des services d'aide linguistique vous sont proposés gratuitement. Si vous êtes un client actuel de Cigna, veuillez appeler le numéro indiqué au verso de votre carte d'identité. Sinon, veuillez appeler le numéro 1.800.244.6224 (ATS : composez le numéro 711).

Portuguese – ATENÇÃO: Tem ao seu dispor serviços de assistência linguística, totalmente gratuitos. Para clientes Cigna atuais, ligue para o número que se encontra no verso do seu cartão de identificação. Caso contrário, ligue para 1.800.244.6224 (Dispositivos TTY: marque 711).

Polish – UWAGA: w celu skorzystania z dostępnej, bezpłatnej pomocy językowej, obecni klienci firmy Cigna mogą dzwonić pod numer podany na odwrocie karty identyfikacyjnej. Wszystkie inne osoby prosimy o skorzystanie z numeru 1 800 244 6224 (TTY: wybierz 711).

Japanese – 注意事項：日本語を話される場合、無料の言語支援サービスをご利用いただけます。現在のCignaのお客様は、IDカード裏面の電話番号まで、お電話にてご連絡ください。その他の方は、1.800.244.6224（TTY: 711）まで、お電話にてご連絡ください。

Italian – ATTENZIONE: Sono disponibili servizi di assistenza linguistica gratuiti. Per i clienti Cigna attuali, chiamare il numero sul retro della tessera di identificazione. In caso contrario, chiamare il numero 1.800.244.6224 (utenti TTY: chiamare il numero 711).

German – ACHTUNG: Die Leistungen der Sprachunterstützung stehen Ihnen kostenlos zur Verfügung. Wenn Sie gegenwärtiger Cigna-Kunde sind, rufen Sie bitte die Nummer auf der Rückseite Ihrer Krankenversicherungskarte an. Andernfalls rufen Sie 1.800.244.6224 an (TTY: Wählen Sie 711).

Persian (Farsi) – توجه: خدمات کمک زبانی، به صورت رایگان به شما ارائه می‌شود. برای مشتریان فعلی Cigna، لطفاً با شماره‌ای که در پشت کارت شناسایی شماست تماس بگیرید. در غیر اینصورت با شماره 1.800.244.6224 تماس بگیرید (شماره تلفن ویژه ناشنوایان: شماره 711 را شماره‌گیری کنید).