

## Cigna Health and Life Insurance Company Delaware 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:\***

- 1<sup>st</sup> 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					<input type="checkbox"/> Male <input type="checkbox"/> Female	
Custodial Parent or Legal Guardian Name (for applicants under the age of 18):					Relationship to Applicant:	
Spouse/Domestic Partner/Civil Union					<input type="checkbox"/> Male <input type="checkbox"/> Female	
Dependent 1					<input type="checkbox"/> Male <input type="checkbox"/> Female	
Dependent 2					<input type="checkbox"/> Male <input type="checkbox"/> Female	
Dependent 3					<input type="checkbox"/> Male <input type="checkbox"/> Female	
Dependent 4					<input type="checkbox"/> Male <input type="checkbox"/> 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 \_\_\_\_\_

**Mailing Address (if different than Home Address):**

Street \_\_\_\_\_  
 \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ ZIP Code \_\_\_\_\_

Preferred Household Email Address\*:

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 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 are the only initial payment methods 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 D 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 D 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 can not 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? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Did you see the proposed applicant at the time this application was completed? <input type="checkbox"/> Yes <input type="checkbox"/> 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 any person who knowingly and with intent to defraud any insurance company or other person files application for insurance or statement of claim containing any material false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits fraudulent insurance act and may be subject to civil and criminal penalties.

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.**

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 Accident and Health Insurance**

According to your application, you intend to lapse or otherwise terminate existing accident and health insurance and replace it with a policy to be issued by Cigna Health and Life Insurance Company. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy.

- (1) You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.
- (2) If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical/health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, reread it carefully to be certain that all information has been properly recorded.

The above "Notice to Applicant" was delivered to me on: \_\_\_\_\_

Primary Applicant Signature:

Today's Date: (MM/DD/YYYY)