Cigna Health and Life Insurance Company
New Jersey Application for Dental Insurance

NONGROUP ENROLLMENT/CHANGE REQUEST

Refer to instructions before completing this form. Print clearly.

A. TYPE OF ACTIVITY - to be completed by Applicant. ***Check all that apply.***

Add

- ☐ Enrollment of a new Primary Applicant Only
- ☐ Enrollment of a new Primary Applicant and Dependent(s)
- ☐ Enrollment of a new Child(ren) Only
- ☐ Add Spouse/Civil Union Partner to existing dental policy
- ☐ Add Domestic Partner to existing dental policy
- ☐ Add Dependent Child to existing dental policy
- ☐ Add Family Member(s) to existing dental policy

Policyholder's Name: _____

ID Number: _____

Other Change

- ☐ Name Change
- ☐ Request Plan Change
- ☐ Other
- ☐ Reinstatement

Policyholder's Name: _____

ID Number: _____

Select requested Effective Date*:

☐ 1st of the Month of _____

*Next available effective date will be assigned if not selected by the applicant.

B. PRIMARY APPLICANT INFORMATION

Primary Applicant Name (Last, First, M.I.):	SSN:	Birthdate (mm/dd/yyyy):	☐ Male ☐ Female

Custodial Parent or Legal Guardian Name (for applicants under the age of 18):	Relationship to Applicant:

Email*:

*By providing your email 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.

Address Information

Home Address Required:

_____

Street/Apt.

_____

City State Zip Code

Mailing Address (if different than Home Address):

_____

Street/Apt.

_____

City State Zip Code

Cell Phone ( )	Home Phone ( )	Work Phone ( )	Primary Applicant's marital status: ☐ Married ☐ Single

Are you covered under Other Dental Coverage? ☐ Yes ☐ No *If Yes:*

Payer Name: _____

Policy #: _____

Why are you applying for individual coverage? _____

Previous Coverage? ☐ Yes ☐ No

If Yes:

Effective Date: _____/_____/_____ Termination Date: _____/_____/_____

Payer Name: _____

Policy # _____

What was it?

☐ Individual

☐ Group

☐ Other *(specify):*

_____

What Plan Type?

☐ Discount dental plan

☐ Preventive only dental plan

☐ Full coverage dental plan

☐ Other *(please explain)*:

_____

C. PLAN OPTION *(Check One)*

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

D. OTHER INDIVIDUALS COVERED - Identify individuals other than yourself for whom you are adding/changing/removing coverage. Attach additional pages if necessary, dated and signed by you.

1. Spouse/Domestic Partner/Civil Union Partner

☐ Add ☐ Remove ☐ Other

Name (Last, First, M.I.):

_____ *(Last)*

_____ _____ *(First)* *(M.I.)*

Birthdate (mm/dd/yyyy): _____

☐ Male ☐ Female

Social Security Number: _____

Previous Dental Coverage? ☐ Yes ☐ No

If Yes:

Effective Date: _____/_____/_____

Termination Date: _____/_____/_____

Payer Name: _____

Policy #: _____

What was it?

☐ Individual

☐ Group

☐ Other *(specify):*

_____

What Plan Type?

☐ Discount dental plan

☐ Preventive only dental plan

☐ Full coverage dental plan

☐ Other *(please explain):*

_____

2. Child

☐ Add ☐ Remove ☐ Other

Name (Last, First, M.I.):

_____ *(Last)*

_____ _____ *(First)* *(M.I.)*

Birthdate (mm/dd/yyyy): _____

☐ Male ☐ Female

Social Security Number: _____

Previous Dental Coverage? ☐ Yes ☐ No

If Yes:

Effective Date: _____/_____/_____

Termination Date: _____/_____/_____

Payer Name: _____

Policy #: _____

What was it?

☐ Individual

☐ Group

☐ Other *(specify):*

_____

What Plan Type?

☐ Discount dental plan

☐ Preventive only dental plan

☐ Full coverage dental plan

☐ Other *(please explain):*

_____

3. Child

☐ Add ☐ Remove ☐ Other

Name (Last, First, M.I.):

_____ *(Last)*

_____ _____ *(First)* *(M.I.)*

Birthdate (mm/dd/yyyy): _____

☐ Male ☐ Female

Social Security Number: _____

Previous Dental Coverage? ☐ Yes ☐ No

If Yes:

Effective Date: _____/_____/_____

Termination Date: _____/_____/_____

Payer Name: _____

Policy #: _____

What was it?

☐ Individual

☐ Group

☐ Other *(specify):*

_____

What Plan Type?

☐ Discount dental plan

☐ Preventive only dental plan

☐ Full coverage dental plan

☐ Other *(please explain):*

_____

4. Child

☐ Add ☐ Remove ☐ Other

Name (Last, First, M.I.):

_____ *(Last)*

_____ _____ *(First)* *(M.I.)*

Birthdate (mm/dd/yyyy): _____

☐ Male ☐ Female

Social Security Number: _____

Previous Dental Coverage? ☐ Yes ☐ No

If Yes:

Effective Date: _____/_____/_____

Termination Date: _____/_____/_____

Payer Name: _____

Policy #: _____

What was it?

☐ Individual

☐ Group

☐ Other *(specify):*

_____

What Plan Type?

☐ Discount dental plan

☐ Preventive only dental plan

☐ Full coverage dental plan

☐ Other *(please explain):*

_____

1. Spouse/Domestic Partner/Civil Union Partner (Continued)

Why did coverage end?

_____

Was continuation upon termination an option?
☐ Yes ☐ No

If Yes:
Was continuation elected and coverage retained for full continuation period? ☐ Yes ☐ No

Does total previous coverage equal 18 months or more?
☐ Yes ☐ No

Any breaks in coverage of more than 63 days?
☐ Yes ☐ No

Covered under Other Dental Coverage Now?
☐ Yes ☐ No

If Yes:
Payer Name: _____

Policy #: _____

Eligible but not covered under Other Dental Coverage? ☐ Yes ☐ No

If Yes, identify the type *:*

☐ Group
Payer Name: _____

☐ Other *(specify)*:

_____

Home address same as Applicant?
☐ Yes ☐ No

If No, complete Section E2

2. Child (Continued)

Why did coverage end?

_____

Was continuation upon termination an option?
☐ Yes ☐ No

If Yes:
Was continuation elected and coverage retained for full continuation period? ☐ Yes ☐ No

Does total previous coverage equal 18 months or more?
☐ Yes ☐ No

Any breaks in coverage of more than 63 days?
☐ Yes ☐ No

Covered under Other Dental Coverage Now?
☐ Yes ☐ No

If Yes:
Payer Name: _____

Policy #: _____

Medicare ID #: _____

Eligible but not covered under Other Dental Coverage? ☐ Yes ☐ No

If Yes, identify the type *:*

☐ Group
Payer Name: _____

☐ Other *(specify)*:

_____

If last name is different from Applicant's please explain: _____

Living with Applicant?
☐ Yes ☐ No

If No, complete Section F

3. Child (Continued)

Why did coverage end?

_____

Was continuation upon termination an option?
☐ Yes ☐ No

If Yes:
Was continuation elected and coverage retained for full continuation period? ☐ Yes ☐ No

Does total previous coverage equal 18 months or more?
☐ Yes ☐ No

Any breaks in coverage of more than 63 days?
☐ Yes ☐ No

Covered under Other Dental Coverage Now?
☐ Yes ☐ No

If Yes:
Payer Name: _____

Policy #: _____

Medicare ID #: _____

Eligible but not covered under Other Dental Coverage? ☐ Yes ☐ No

If Yes, identify the type *:*

☐ Group
Payer Name: _____

☐ Other *(specify)*:

_____

If last name is different from Applicant's please explain: _____

Living with Applicant?
☐ Yes ☐ No

If No, complete Section F

4. Child (Continued)

Why did coverage end?

_____

Was continuation upon termination an option?
☐ Yes ☐ No

If Yes:
Was continuation elected and coverage retained for full continuation period? ☐ Yes ☐ No

Does total previous coverage equal 18 months or more?
☐ Yes ☐ No

Any breaks in coverage of more than 63 days?
☐ Yes ☐ No

Covered under Other Dental Coverage Now?
☐ Yes ☐ No

If Yes:
Payer Name: _____

Policy #: _____

Medicare ID #: _____

Eligible but not covered under Other Dental Coverage? ☐ Yes ☐ No

If Yes, identify the type *:*

☐ Group
Payer Name: _____

☐ Other *(specify)*:

_____

If last name is different from Applicant's please explain: _____

Living with Applicant?
☐ Yes ☐ No

If No, complete Section F

E. ADDITIONAL SPOUSE/DOMESTIC PARTNER/CIVIL UNION PARTNER INFORMATION - If not applicable, please mark as "NA."

2a.

_____
Street/Apt.

_____
City State Zip Code

2b. Please explain why the address is different:

_____

_____

_____

F. ADDITIONAL CHILD INFORMATION - Provide information below about children listed in Section D, if they have a different address. If multiple children are at an address, you may list them together. Attach additional pages as necessary, signed and dated.

Name(s)	Name(s)
Name(s)	Name(s)
Street/Apt.	Street/Apt.
City State Zip Code	City State Zip Code
Reason	Reason

G. 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 B 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. I also understand that failure to pay my health care contract premium may result in termination of my health care contract. 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 dental 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 B 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 B 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.

H. CONDITIONS OF ENROLLMENT - APPLICANT ACKNOWLEDGEMENTS AND AGREEMENTS

On behalf of myself and the dependents listed in this Enrollment/Change Request form, I acknowledge that:

1. I authorize any physician or dental professional, hospital, clinic or other dental care institution, carrier, consumer reporting agency, and any employer to give Cigna Health and Life Insurance Company, or any consumer reporting agency acting on behalf of Cigna Health and Life Insurance Company, information pertaining to employment, other dental coverage, and dental advice, treatment or supplies for any dental condition relevant to me or a minor dependent applying for coverage. I agree that this authorization shall be valid for 30 months from the date I sign this Enrollment/Change Request form, unless revoked at an earlier date.
2. I agree that, if I revoke this authorization before it expires, such revocation shall not affect any action that Cigna Health and Life Insurance Company has taken in reliance on the authorization.
3. I understand I may receive a copy of this authorization if I request one.
4. I agree Cigna Health and Life Insurance Company will provide coverage in accordance with the terms of the contract for the individual plan policy.
5. I understand that my enrollment and the enrollment of my listed dependents in Cigna Health and Life Insurance Company's individual plan policy is effective upon acceptance by Cigna Health and Life Insurance Company.
6. I agree that the provision of coverage and benefits is contingent upon payment of premiums and may be terminated in accordance with the terms of the individual plan policy if premiums are not paid timely.
7. I understand that I or my authorized representative is entitled to receive a copy of this authorization form.
8. 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.
9. 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.

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. For individuals under the age of 19, please note that this dental plan does not meet the essential health benefits of a pediatric dental plan. 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. 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.

I. PRIMARY APPLICANT'S SIGNATURE

I represent that all the information supplied in this application is true and complete. I hereby agree to the Conditions of Enrollment set forth in this Enrollment/Change Request form.

Primary Applicant's 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)

J. 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

K. 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:

L. 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's Signature:	Today's Date: (MM/DD/YYYY)

MISREPRESENTATIONS

Any person who includes any false or misleading information on a Nongroup Enrollment/Change Request Form for a health benefits plan is subject to criminal and civil penalties.

INSTRUCTIONS AND ELIGIBILITY REQUIREMENTS

INSTRUCTIONS

- You must complete sections A through L, and sign and date this form, as well as any additional pages you may need to submit with it to provide further requested information.
- Please PRINT except when a signature is requested.
- If a dependent child is disabled and you want to continue his or her coverage beyond age 26, describe this in "Other Change" in Section A, and attach proof of disability.
- "Previous Coverage" and "Other Dental Coverage" includes coverage under a: group health plan resulting from employment, whether with a private or public (governmental) employer, including such coverage continued through a COBRA election or state continuation provisions; a church plan, or another individual dental benefits plan.
- IF YOU HAVE ANY QUESTIONS concerning the benefits and services provided by or excluded under this policy, contact a member services representative at 1-866-GET-Cigna (1-866-438-2446) before signing this form.
- KEEP A COPY OF THIS COMPLETED APPLICATION! A copy of this application may be used as a temporary ID card for 30 days from the effective date if authorized by Cigna Health and Life Insurance Company. Coverage must be verified with Cigna Health and Life Insurance Company prior to visiting with a Dentist.

ELIGIBILITY

A. You MUST be a New Jersey resident.

B. If you do not specify an effective date in the application, your effective date shall be no later than the first or fifteenth day of the month following the date the completed application was dated and we receive premium payment directly or through our duly authorized agent.

C. You SHOULD NOT terminate current coverage until the new coverage is effective.

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

- 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.

DISCRIMINATION IS AGAINST THE LAW

Dental 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.

911105 10/17

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).