



CIGNA HealthCare

MEMBERSHIP APPLICATION & CHANGE FORM

WELCOME TO CIGNA HEALTHCARE!

* Please be sure to complete this entire application and retain the PINK copy to serve as your temporary ID Card.

PLEASE NOTE THAT CIGNA HEALTHCARE CANNOT PROCESS YOUR APPLICATION WITHOUT ALL SECTIONS COMPLETED.

It is very important to complete every applicable question. Failure to do so will delay the commencement of coverage.

If you are enrolling a dependent(s) age 19 or older, please complete the Questionnaire for Dependent(s) Age 19 or Older attached to the back of this application. Please return the completed form to CIGNA HealthCare or your employer/benefits office as soon as possible. Your dependent(s) will not be added to your coverage until the completed form has been received.

PRIMARY CARE PHYSICIAN (PCP) SELECTION - PRIMARY SOURCE

* **Choose your own Primary Care Physician (PCP) from the front section of the CIGNA HealthCare Provider Directory.** When you join a CIGNA HealthCare health plan, each member of your family must choose a PCP to coordinate all medical care. Each family member may select a different PCP (i.e., Family Practice, Internal Medicine, or Pediatric). We encourage you to review the symbols listed in the directory to assist you (i.e., “*” indicates that the physician is limited to current patients only). Therefore, you must be a current patient of the office in order to designate the physician as your PCP.

Do you need assistance in selecting a PCP? Please call us at (800) 531-4584 and speak with a Member Services Representative for assistance.

How To Complete This Application

- 1 SUBSCRIBER INFORMATION**
The employee should complete this section. If you are joining CIGNA HealthCare for the first time, please check the NEW SUBSCRIBER box.
- 2 SUBSCRIBER & DEPENDENT(S) INFORMATION**
Complete this section for yourself, your spouse and any dependent(s) to be covered.
- 3 PRIMARY CARE PHYSICIAN**
Refer to Provider Directory and indicate your Primary Care Physician selection here.
- 4 OTHER DEPENDENT(S) INFORMATION**
Please read this section and complete it if it pertains to your personal situation.
- 5 OTHER INSURANCE COVERAGE INFORMATION**
If you are transferring from another Group Health Plan or if you will have other coverage along with this plan, please complete this section.
- 6 EMPLOYEE SIGNATURE**
Employee must sign and date this application.
- 7 EMPLOYER COMPLETE**
Please return application back to your employer for signature, group number, product selection, and effective date.

CIGNA HealthCare of New Hampshire, Inc.
PO Box 2041
Concord, NH 03302-2041

CIGNA HealthCare Membership Application & Change Form

Group # _____ Subscriber # _____ Effective Date _____

CHECK DESIRED COVERAGE TYPE
 HMO MEMBER SELECT POS
Every option may not be available to you. Please verify that your group is offering the coverage you wish to select.

CHECK REASON FOR COMPLETING APPLICATION
 New Subscriber
 Name Change Address Change
 Primary Care Physician Change
 Election of COBRA Coverage
 Enroll a Family Member
 Disenroll a Family Member
 Cancellation of Policy
 Conversion to Nongroup
 Waiver of Insurance Election
 Retired
 Explanation of Change _____

SUBSCRIBER INFORMATION (EMPLOYEE INFORMATION)

Last _____ First _____ MI _____
 Home Address: If the address is a PO box, please also include street address. City _____ State _____ Zip _____
 Company Name _____
 Telephone: Home _____ Work _____
 () () ()

STATUS (Check)
 Single Separated Type of Coverage Requested
 Married Divorced Individual Parent/Children
 Widowed Retired Two Person Family

Please use the Provider Directory to choose a Primary Care Physician for yourself and each of your covered dependent(s). If your dependent(s) are age 19 or older complete the form attached to the back of this application within 30 days.

SUBSCRIBER AND DEPENDENT(S) INFORMATION		Relationship to Subscriber	Resides in Subscriber's Home	Sex M/F	If dependent is over 19, check Full-time Student Disabled	Transferring Coverage from Another Carrier	Primary Care Physician (First & Last Name)	Current Patient
01	EMPLOYEE NAME					Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>
02	SPOUSE NAME					Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>
03	DEPENDENT NAME					Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>
04	DEPENDENT NAME					Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>
05	DEPENDENT NAME					Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

OTHER DEPENDENT(S) INFORMATION

Dependent(s) of Legally Divorced Parents: Who does the child reside with? Natural Mother Natural Father Other Does the dependent have other group insurance? Yes No Partial

If yes, indicate effective date and name of insurance company _____
 Dependent Address (if different): No. & Street _____ Home Telephone () _____
 City _____ State _____ Zip Code _____ Work Telephone () _____

OTHER INSURANCE COVERAGE INFORMATION

Do you or your family have health coverage through another group or employer? Yes No
 To join CIGNA HealthCare, please indicate the other carrier(s) Yes No If transferring coverage from any other carrier(s) Yes No

Names of individuals who have other coverage _____ Policyholder _____ Policy # _____
 Name of insurance company _____ Name of insurance _____ Policy Number _____
 Is spouse employed? Yes No _____ Effective Date _____ Term Date _____

Is there a divorce decree establishing insurance responsibility? Yes No If yes, please provide CIGNA HealthCare the portion of the decree which states this responsibility. (Attach if previously sent.)

In completing this Application, I agree to the following for myself and all eligible dependent(s):

- That any hospital or physician may furnish CIGNA HealthCare such medical information as may be required to conduct a professional utilization review program of health services, and to coordinate benefits and/or reimbursements with other health or insurance programs.
- I acknowledge that copies of the CIGNA HealthCare Group Subscriber Agreement and Provider Directory are available with my employer for my review and understand that the benefits for which (we) will be eligible are those described in the Group Subscriber Agreement.
- HMO & MEMBER SELECT ONLY:** I (we) fully understand that my (our) Primary Care Physician(s) must provide or authorize all medical and hospital care except in a medical emergency.
- POS ONLY:** I fully understand that to receive reimbursement at the in-network benefit payment level my Primary Care physician must provide or authorize all medical and hospital care except in a medical emergency.
- That any dispute or claim be resolved according to the Grievance Procedures Section of the Group Subscriber Agreement.
- That all information furnished by me is true and complete to the best of my knowledge.

Employee Signature: X _____ Date: _____

EMPLOYER COMPLETE 1 - 6			CIGNA HEALTHCARE COMPLETE 7	
1. GROUP NUMBER	3. DATE OF EMPLOYMENT	5. COMMENTS	7. DATE ENTERED	
2. EFFECTIVE DATE	4. COMPANY REPRESENTATIVE SIGNATURE	6. DATE		

MKFHMSLAPP 576669 (REV. 7/00)

***Questions? For HMO & MEMBER SELECT** please call us at (800) 291-2466, **For POS** please call us at (800) 531-4005, Monday through Thursday, 8:00 am - 6:00 pm & Friday, 8:00 am - 5:30 pm.

CIGNA HealthCare Membership Application & Change Form

CIGNA HealthCare Use Only.

Group # _____ **Subscriber #** _____ **Effective Date** _____

CHECK DESIRED COVERAGE TYPE

HMO MEMBER SELECT POS
Every option may not be available to you. Please verify that your group is offering the coverage you wish to select.

CHECK REASON FOR COMPLETING APPLICATION

New Subscriber
 Name Change Address Change
 Primary Care Physician Change
 Election of COBRA Coverage
 Enroll a Family Member
 Disenroll a Family Member
 Cancellation of Policy
 Conversion to Nongroup
 Waiver of Insurance Election

Explanation of Change _____

SUBSCRIBER INFORMATION (EMPLOYEE INFORMATION)

Last _____ First _____ MI _____

Home Address: *If the address is a PO Box, please also indicate street address.* City _____ State _____ Zip _____

Company Name _____

Telephone: Home _____ Work _____
 () ()

STATUS (Check)
 Single Separated
 Married Divorced
 Widowed Retired

Type of Coverage Requested
 Individual Parent/Children
 Two Person Family

Please use the Provider Directory to choose a Primary Care Physician for yourself and each of your covered dependent(s). If your dependent(s) is/are age 19 or older complete the form attached to the back of this application within 30 days.

SUBSCRIBER AND DEPENDENT(S) INFORMATION

NAME (First, Mid., Last) <i>Social Security Number for Employee, Spouse and Dependent(s) required for processing.</i>	Date of Birth Mo/Day/Yr	Relation to Subscriber	Resides in Subscriber's Home	Sex M/F	If dependent is over 19, check		Transferring Coverage from Another Carrier	Primary Care Physician (First & Last Name)	Current Patient
					Full-time Student	Disabled			
01 EMPLOYEE NAME <i>Social Security #</i>						<input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>
02 SPOUSE NAME <i>Social Security #</i>						<input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>
03 DEPENDENT NAME <i>Social Security #</i>			Yes <input type="checkbox"/> No <input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>
04 DEPENDENT NAME <i>Social Security #</i>			Yes <input type="checkbox"/> No <input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>
05 DEPENDENT NAME <i>Social Security #</i>			Yes <input type="checkbox"/> No <input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

OTHER DEPENDENT(S) INFORMATION

Dependent(s) of Legally Divorced Parents: _____ **Does the dependent(s) have other group insurance?**
 Yes No **Parent Name** _____

Who does the child reside with? Natural Mother Natural Father

If yes, indicate effective date and name of Insurance Company _____

Dependent Address (if different): No. & Street _____ **Home Telephone ()** _____

City _____ **State** _____ **Zip Code** _____ **Work Telephone ()** _____

OTHER INSURANCE COVERAGE INFORMATION

Do you or your family have health coverage through another group or employer? Yes No

Names of individuals who have other coverage _____

Name of Insurance Company _____ Policyholder _____ Policy # _____

Is spouse employed? Yes No

Is there a divorce decree establishing insurance responsibility? Yes No If yes, please provide CIGNA HealthCare the portion of the decree which states this responsibility. (Disregard if previously sent.)

To join CIGNA HealthCare are you transferring your coverage from any other carrier? Yes No

Name _____

Name of Insurance Co. _____

Policy Number _____

Effective Date _____ Term Date _____

- In completing this Application, I agree to the following for myself and all eligible dependent(s):
- That any hospital or physician may furnish CIGNA HealthCare such medical information as may be required to conduct a professional utilization review program of health services, and to coordinate benefits and/or reimbursements with other health or insurance programs.
 - I acknowledge that copies of the CIGNA HealthCare Group Subscriber Agreement and Provider Directory are available with my employer for my review and understand that the benefits for which (we) will be eligible are those described in the Group Subscriber Agreement.
 - HMO & MEMBER SELECT ONLY:** I (we) fully understand that my (our) Primary Care Physician(s) must provide or authorize all medical and hospital care except in a medical emergency.
 - POS ONLY:** I fully understand that to receive reimbursement at the in-network benefit payment level my Primary Care Physician must provide or authorize all medical and hospital care except in a medical emergency.
 - That any dispute or claim be resolved according to the Grievance Procedures Section of the Group Subscriber Agreement.
 - That all information furnished by me is true and complete to the best of my knowledge.

Employee Signature: X _____ Date: _____

EMPLOYER COMPLETE 1 - 6

1. GROUP NUMBER	3. DATE OF EMPLOYMENT	5. COMMENTS
2. EFFECTIVE DATE	4. COMPANY REPRESENTATIVE SIGNATURE	6. DATE

CIGNA HEALTHCARE COMPLETE 7

7. DATE ENTERED _____

CIGNA HealthCare Membership Application & Change Form

CIGNA HealthCare Use Only.

Group # _____ **Subscriber #** _____ **Effective Date** _____

CHECK DESIRED COVERAGE TYPE

HMO MEMBER SELECT POS
Every option may not be available to you. Please verify that your group is offering the coverage you wish to select.

CHECK REASON FOR COMPLETING APPLICATION

New Subscriber
 Name Change Address Change
 Primary Care Physician Change
 Election of COBRA Coverage
 Enroll a Family Member
 Disenroll a Family Member
 Cancellation of Policy
 Conversion to Nongroup
 Waiver of Insurance Election

Explanation of Change _____

SUBSCRIBER INFORMATION (EMPLOYEE INFORMATION)

Last _____ First _____ MI _____

Home Address: *If the address is a PO Box, please also indicate street address.* City _____ State _____ Zip _____

Company Name _____

Telephone: Home _____ Work _____
 () ()

STATUS (Check)
 Single Separated
 Married Divorced
 Widowed Retired

Type of Coverage Requested
 Individual Parent/Children
 Two Person Family

Please use the Provider Directory to choose a Primary Care Physician for yourself and each of your covered dependent(s). If your dependent(s) is/are age 19 or older complete the form attached to the back of this application within 30 days.

SUBSCRIBER AND DEPENDENT(S) INFORMATION

NAME (First, Mid., Last) <i>Social Security Number for Employee, Spouse and Dependent(s) required for processing.</i>	Date of Birth Mo/Day/Yr	Relation to Subscriber	Resides in Subscriber's Home	Sex M/F	If dependent is over 19, check		Transferring Coverage from Another Carrier	Primary Care Physician (First & Last Name)	Current Patient
					Full-time Student	Disabled			
01 EMPLOYEE NAME <i>Social Security #</i>						<input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>
02 SPOUSE NAME <i>Social Security #</i>						<input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>
03 DEPENDENT NAME <i>Social Security #</i>			Yes <input type="checkbox"/> No <input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>
04 DEPENDENT NAME <i>Social Security #</i>			Yes <input type="checkbox"/> No <input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>
05 DEPENDENT NAME <i>Social Security #</i>			Yes <input type="checkbox"/> No <input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

OTHER DEPENDENT(S) INFORMATION

Dependent(s) of Legally Divorced Parents: _____ **Does the dependent(s) have other group insurance?** _____
 Yes No **Parent Name** _____

Who does the child reside with? Natural Mother Natural Father

If yes, indicate effective date and name of Insurance Company _____

Dependent Address (if different): No. & Street _____ **Home Telephone ()** _____

City _____ **State** _____ **Zip Code** _____ **Work Telephone ()** _____

OTHER INSURANCE COVERAGE INFORMATION

Do you or your family have health coverage through another group or employer? Yes No

Names of individuals who have other coverage _____

Name of Insurance Company _____ Policyholder _____ Policy # _____

Is spouse employed? Yes No

Is there a divorce decree establishing insurance responsibility? Yes No If yes, please provide CIGNA HealthCare the portion of the decree which states this responsibility. (Disregard if previously sent.)

To join CIGNA HealthCare are you transferring your coverage from any other carrier? Yes No

Name _____

Name of Insurance Co. _____

Policy Number _____

Effective Date _____ Term Date _____

- In completing this Application, I agree to the following for myself and all eligible dependent(s):
- That any hospital or physician may furnish CIGNA HealthCare such medical information as may be required to conduct a professional utilization review program of health services, and to coordinate benefits and/or reimbursements with other health or insurance programs.
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Employee Signature: X _____ Date: _____

EMPLOYER COMPLETE 1 - 6

1. GROUP NUMBER	3. DATE OF EMPLOYMENT	5. COMMENTS
2. EFFECTIVE DATE	4. COMPANY REPRESENTATIVE SIGNATURE	6. DATE

CIGNA HEALTHCARE COMPLETE 7

7. DATE ENTERED _____

CIGNA HealthCare Membership Application & Change Form

CIGNA HealthCare Use Only.

Group # _____ **Subscriber #** _____ **Effective Date** _____

CHECK DESIRED COVERAGE TYPE

HMO MEMBER SELECT POS
Every option may not be available to you. Please verify that your group is offering the coverage you wish to select.

CHECK REASON FOR COMPLETING APPLICATION

New Subscriber
 Name Change Address Change
 Primary Care Physician Change
 Election of COBRA Coverage
 Enroll a Family Member
 Disenroll a Family Member
 Cancellation of Policy
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 Waiver of Insurance Election

Explanation of Change _____

SUBSCRIBER INFORMATION (EMPLOYEE INFORMATION)

Last _____ First _____ MI _____

Home Address: *If the address is a PO Box, please also indicate street address.* City _____ State _____ Zip _____

Company Name _____

Telephone: Home _____ Work _____
 () ()

STATUS (Check)
 Single Separated
 Married Divorced
 Widowed Retired

Type of Coverage Requested
 Individual Parent/Children
 Two Person Family

Please use the Provider Directory to choose a Primary Care Physician for yourself and each of your covered dependent(s). If your dependent(s) is/are age 19 or older complete the form attached to the back of this application within 30 days.

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01 EMPLOYEE NAME <i>Social Security #</i>						<input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>
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04 DEPENDENT NAME <i>Social Security #</i>			Yes <input type="checkbox"/> No <input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>
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OTHER DEPENDENT(S) INFORMATION

Dependent(s) of Legally Divorced Parents: _____ **Does the dependent(s) have other group insurance?**
 Yes No **Parent Name** _____

Who does the child reside with? Natural Mother Natural Father

If yes, indicate effective date and name of Insurance Company _____

Dependent Address (if different): No. & Street _____ **Home Telephone ()** _____

City _____ **State** _____ **Zip Code** _____ **Work Telephone ()** _____

OTHER INSURANCE COVERAGE INFORMATION

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Names of individuals who have other coverage _____

Name of Insurance Company _____ Policyholder _____ Policy # _____

Is spouse employed? Yes No

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Name _____

Name of Insurance Co. _____

Policy Number _____

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Employee Signature: X _____ Date: _____

EMPLOYER COMPLETE 1 - 6

1. GROUP NUMBER	3. DATE OF EMPLOYMENT	5. COMMENTS
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CIGNA HEALTHCARE COMPLETE 7

7. DATE ENTERED _____

CIGNA HealthCare Membership Application & Change Form

CIGNA HealthCare Use Only.

Group # _____ **Subscriber #** _____ **Effective Date** _____

CHECK DESIRED COVERAGE TYPE

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01 EMPLOYEE NAME <i>Social Security #</i>						<input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>
02 SPOUSE NAME <i>Social Security #</i>						<input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>
03 DEPENDENT NAME <i>Social Security #</i>			Yes <input type="checkbox"/> No <input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>
04 DEPENDENT NAME <i>Social Security #</i>			Yes <input type="checkbox"/> No <input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>
05 DEPENDENT NAME <i>Social Security #</i>			Yes <input type="checkbox"/> No <input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>

OTHER DEPENDENT(S) INFORMATION

Dependent(s) of Legally Divorced Parents: _____ **Does the dependent(s) have other group insurance?**
 Yes No **Parent Name** _____

Who does the child reside with? Natural Mother Natural Father

If yes, indicate effective date and name of Insurance Company _____

Dependent Address (if different): No. & Street _____ **Home Telephone ()** _____

City _____ **State** _____ **Zip Code** _____ **Work Telephone ()** _____

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Name of Insurance Company _____ Policyholder _____ Policy # _____

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Name _____

Name of Insurance Co. _____

Policy Number _____

Effective Date _____ Term Date _____

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Employee Signature: X _____ Date: _____

EMPLOYER COMPLETE 1 - 6

1. GROUP NUMBER	3. DATE OF EMPLOYMENT	5. COMMENTS
2. EFFECTIVE DATE	4. COMPANY REPRESENTATIVE SIGNATURE	6. DATE

CIGNA HEALTHCARE COMPLETE 7

7. DATE ENTERED _____



CIGNA HealthCare

CIGNA HealthCare of New Hampshire, Inc.
PO Box 2041
Concord, NH 03302-2041

NEW SUBSCRIBER: Thank you for choosing CIGNA HealthCare. Please keep pink copy as your temporary ID card until you receive a permanent one. As soon as your enrollment becomes effective, CIGNA HealthCare is responsible for your medical care. Please call your Primary Care Physician for regular appointments, urgent care, and emergencies.

FOR APPOINTMENTS: Call your Primary Care Physician's office.

FOR EMERGENCY CARE: Call your Primary Care Physician and follow the physician's instructions. If it is a medical emergency, go to the nearest emergency room and notify your Primary Care Physician as soon as possible. Failure to promptly notify your Primary Care Physician may result in your claim not being approved for payment.

OUT-OF-AREA CARE: If you have an emergency or urgent situation while you are away from home, you may use a non-CIGNA HealthCare physician. You must notify your Primary Care Physician as soon as possible, at least within 48 hours, so that your Primary Care Physician can coordinate your follow-up care.

FOR OTHER QUESTIONS: The CIGNA HealthCare Member Services Department will answer any questions you may have. **For HMO & MEMBER SELECT** questions call us at (800) 291-2466. **For POS questions** call us at (800) 531-4005.

Return to:



CIGNA HealthCare

CIGNA HealthCare of New Hampshire, Inc.

PO Box 2041

Concord, NH 03302-2041

Attn: Enrollment Department

Dependent(s) Age 19 or Older Questionnaire

Please Print or Type.

**PLEASE COMPLETE ONLY THE NECESSARY SECTIONS (A OR B) AND FORWARD TO YOUR SCHOOL (SECTION A) OR PHYSICIAN (SECTION B).
PLEASE COMPLETE WITHIN 30 DAYS.**

A. UNMARRIED FULL-TIME STUDENT

IF YOUR DEPENDENT IS ATTENDING SCHOOL, PLEASE COMPLETE THE INFORMATION BELOW AND HAVE THE SCHOOL REGISTRAR SIGN AND SEAL THIS FORM.

Employee Name

Employer Name

Dependent Name

Social Security #

Student Status

Full-Time

Part-Time

Number of Credits

Date Current Semester Began

Student Enrolled

Last Semester

Yes No

▼ SEAL AREA ▼

School Name

School Address

Phone #

Registrar's Signature

X

FORM IS NOT VALID WITHOUT REGISTRAR'S SEAL

B. MENTAL OR PHYSICALLY DISABLED: ATTENDING PHYSICIAN'S STATEMENT

PLEASE HAVE YOUR DEPENDENT'S ATTENDING PHYSICIAN COMPLETE AND SIGN THE STATEMENT BELOW, IF YOUR DEPENDENT(S) HAS A MENTAL OR PHYSICAL DISABILITY.

Employee Name

Employer Name

Dependent Name

Relationship

Employee Social Security #

1. Nature and degree of mental and physical disability. (Please furnish full diagnosis):

2. How and when above condition commenced:

3. Date individual was last examined:

4. a) Does the disability restrict the individual's ability to engage in activities of daily living? Yes No

b) Extent of disability: Full Partial Permanent Temporary

5. Is patient now totally disabled for:

a) Any occupation Yes No

b) Previous occupation Yes No

c) If Yes to either: when do you think patient will be able to return to work? Approximate Date Indefinite Never
is the patient a suitable candidate for a rehabilitation program? Yes No

6. Please furnish CIGNA HealthCare with any other information which you think would help us make a fair disability determination.

Signature: X _____ M.D./D.O. Date: _____

Address: _____