INSURANCE ENROLLMENT FORM

Please use this form to apply for coverage. Simply fill in any missing information below. Don't forget to include your Social Security Number, Birthdate, sign your name and enter today's date.

Cigna

Life Insurance Company of North America

Employer: City of Commerce City

ALL ABOUT YOU – THE EMPLOYEE

Your Name _____ Social Security # _____ Birthdate _____

Address _____ City _____ State _____ Zip _____

Email _____ Phone _____ Employee ID # _____ Gender _____

COMPLETE THIS SECTION ONLY IF YOU WANT COVERAGE FOR YOUR SPOUSE*

☐ I am currently married and my date of marriage is:_____

Name _____ Social Security # _____ Birthdate _____ Gender ___

YOUR COVERAGE ELECTIONS

Employee-Paid (Voluntary) Critical Illness Insurance – Policy # CI961856

Choose an amount and who you would like to include in your coverage. See the Summary of Benefits for Bi-Weekly costs.

	Coverage Amount	Acceptance
☐ Employee Only ☐ Employee + Spouse/Domestic Partner ☐ Employee + Children ☐ Employee + Family # of covered children ____	☐ $5,000 ☐ $10,000 ☐ $20,000 ☐ $30,000**	☐ Accept Coverage ☐ Decline Coverage

*If elected, Spouse and Child(ren) receive a percentage of employee elected coverage amount. **This is the Guarantee coverage amount. You may elect up to this amount during this enrollment. If you elect an amount greater than the Guarantee Coverage Amount you will be required to complete an Evidence of Insurability form.*

Employee-Paid (Voluntary) Accidental Injury Insurance – Policy # AI961946

Choose the plan and who you would like to include in your coverage. See the Summary of Benefits for Bi-Weekly costs.

	Plan	Acceptance
☐ Employee Only ☐ Employee + Spouse/Domestic Partner ☐ Employee + Children ☐ Employee + Family # of covered children ____	☐ Plan	☐ Accept Coverage ☐ Decline Coverage

Employee-Paid (Voluntary) Hospital Care Insurance – Policy # HC961133

Choose the plan and who you would like to include in your coverage. See the Summary of Benefits for Bi-Weekly costs.

	Plan	Acceptance
☐ Employee Only ☐ Employee + Spouse/Domestic Partner ☐ Employee + Children ☐ Employee + Family # of covered children ____	☐ Plan 1 ☐ Plan 2	☐ Accept Coverage ☐ Decline Coverage

*For purposes of this brochure, wherever the term Spouse appears, it shall also include Domestic Partner and Domestic Partners registered under any state which legally recognizes Domestic Partnerships or Civil Unions. Additional information is available from your Benefit Service Representative.

For California Residents: By signing below, I certify that I and my dependents for whom I am applying for coverage are currently covered for comprehensive health benefits from an insurance policy, an HMO policy, or an employer health benefit plan. Anyone who is not currently covered for comprehensive health benefits is NOT eligible for Critical Illness and/or Hospital Care coverage.

Maryland residents: Caution: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit, or who knowingly or willfully presents false information in an application for insurance, is guilty of a crime and may be subject to fines and confinement in prison.
Oregon residents: Caution: Any person who, knowingly and with intent to defraud any insurance company or other person: (1) files an application for insurance or statement of claim containing any materially false information; or (2) conceals for the purpose of misleading, information concerning any fact material thereto; commits a fraudulent insurance act may be guilty of fraud and may be subject to civil or criminal penalties if intentional and material to the risk.
Vermont residents: Caution: Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

Please turn to the other side to complete the enrollment process. Be sure to make a copy for your records.

SIGN HERE TO ACCEPT DEDUCTION FROM YOUR PAYCHECK

I accept the insurance options chosen above. If premiums are to be paid by payroll, I authorize my employer to deduct the necessary amounts from my paycheck. If I did not choose coverage now, and I decide I want coverage at a later date, I may be required to provide evidence of insurability at my own expense. I understand that coverage is subject to Cigna's approval and that my insurance will not go into effect unless I am actively at work on the effective date. I also understand that coverage for each of my dependents will go into effect only if the person is not confined in a hospital or institution, or receiving certain medical treatment. I understand my information is protected by privacy laws and will be released only in accordance with these laws. Additional information about the rules and conditions around the requested insurance is described in the policy and certificate. Insurance coverage is underwritten by Life Insurance Company of North America.

Please Sign Here  Signature _____ Date _____

Please turn to the other side to complete the enrollment process. Be sure to make a copy for your records.