Application Submission Instructions

Please complete the attached application and send to HealthPlanOne either via fax or mail: (must submit by mail if enclosing a check or money order)

HealthPlanOne
35 Nutmeg Drive, Suite 220
Trumbull, CT 06611

Fax (Toll Free): 888.812.6887

Please make check payable to the carrier to which you are applying.

Any questions? Please call HealthPlanOne at 1-877.567.5267. Thank you!
Cigna Health and Life Insurance Company
Florida Individual and Family Plan Enrollment Application / Change Form

Our medical plans are only available in the following services areas/counties:
Tampa: Hernando, Hillsborough, Lee, Manatee, Pasco, Pinellas, Polk, Sarasota
Orlando: Brevard, Flagler, Indian River, Lake, Orange, Osceola, Seminole, Sumter, Volusia
South Florida: Broward, Martin, Miami-Dade, Monroe, Palm Beach, St. Lucie

Section A. Type of Application

New Enrollment Application:
☐ Applicant Only  ☐ Applicant and Dependent(s)  ☐ Child(ren) Only

Existing Individual Plan Policy Member requesting a change in coverage:
☐ Add Family Member(s)  or  ☐ Request Plan Change

Subscriber Name: ______________________________  Subscriber ID: ______________________________

Requested Effective Date:*  1st of the Month of ______________________________

* 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.

Effective dates are assigned to the 1st of the month. Cigna Health and Life Insurance Company will assign the next available effective date if not selected by the applicant.

Section B. Enrollment Criteria

Applications are accepted during annual open enrollment period or when an applicant experiences a Qualifying (Triggering) Life Event. Please select the applicable enrollment reason.

☐ Annual Open Enrollment
☐ Special Enrollment Period (Select the qualifying event below).

To apply for Special Enrollment Period an applicant must experience a Qualifying (Triggering) Life Event and has 60 days from the date of that event, (including the date of the actual event) to apply for coverage. Triggering events do not include loss of coverage due to failure to make premium payments on a timely basis, including COBRA premiums prior to expiration of COBRA coverage; and situations allowing for a rescission under federal law. Please select the applicable qualifying event reason(s) and date(s) below in order to determine your effective date and plan eligibility. Valid documentation will be required to be submitted for all Special Enrollment events.

☐ An eligible individual, and any dependent(s), loses his or her minimum essential coverage for reasons other than the reasons stated above
☐ An eligible individual gained or became a dependent through marriage or civil union
☐ An eligible individual gained or became a dependent through birth, adoption, or placement for adoption, or placement in foster care
☐ An eligible individual experienced an error in enrollment
☐ An eligible individual or enrollee made a permanent move and new coverage is available
☐ An eligible individual and his or her dependent(s) lose employer-sponsored health plan coverage due to involuntary termination of employment for reasons other than misconduct, or due to a reduction in work hours
☐ An eligible dependent spouse or child loses coverage under an employer-sponsored health plan due to employee’s becoming entitled to Medicare, divorce or legal separation of the covered employee, and death of the covered employee
☐ An eligible individual loses his or her dependent child status under a parent’s employer-sponsored health plan
☐ An eligible individual is mandated to be covered as a dependent pursuant to a valid court order, including child support

For any Special Enrollment Period reason, provide:
Name(s): ___________________________________________________________ and Event Date(s): __________________________

Section C. Benefit Plan Options

Select Desired Medical Benefit Plan:  Select Desired Dental Benefit Plan:  Select Desired Dental Benefit Plan:
☐ Cigna Vantage HSA Bronze 6000  ☐ Cigna Dental Preventative  ☐ Cigna Dental Preventative
☐ Cigna Vantage Flex Bronze 6400  ☐ Cigna Dental 1000  ☐ Cigna Dental 1000
☐ Cigna Vantage Flex Silver 1900  ☐ Cigna Dental 1500  ☐ Cigna Dental 1500
☐ Cigna Vantage Flex Silver 2750  ☐ Cigna Dental 1500  ☐ Cigna Dental 1500
☐ Cigna Vantage Flex Silver 5000  ☐ Cigna Dental 1500  ☐ Cigna Dental 1500
☐ Cigna Vantage Flex Gold 1000  ☐ Cigna Dental 1500  ☐ Cigna Dental 1500

For Cigna Health Savings Plan please call Broker Support.
# Section D. Applicant, Spouse and Dependent Information

## Applicant's Last Name: ___________________________  First Name: ___________________________  M.I.: ______  iTIN: ___________________________

- **Date of Birth:**
  - Age: ______
  - [ ] Single
  - [ ] Married
  - [ ] Male
  - [ ] Female

- **Select your choice of Primary Care Physician (PCP):**
  - First Name: ___________________________  Last Name: ___________________________
  - PCP ID Number: ______

*Plans with this asterisk mean a PCP is required. If you do not select a PCP, one will be assigned for you.

- **Current Patient:**
  - [ ] Yes
  - [ ] No

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

- **Mailing Address – Home Address Required**
  - Street: ___________________________
  - City: ___________________________
  - State: ___________________________
  - ZIP Code: ______

- **Billing Address – If different than mailing address**
  - Street: ___________________________
  - City: ___________________________
  - State: ___________________________
  - ZIP Code: ______

- **Home Phone Number:** ( ) ______ - ______
- **Cell Phone Number:** ( ) ______ - ______
- **Work Phone Number:** ( ) ______ - ______

## Applicant’s Language Preference

**Spoken Language Preference (Select only one)**

- [ ] EN English
- [ ] ES Spanish
- [ ] 12 Cantonese
- [ ] 14 Mandarin
- [ ] VI Vietnamese
- [ ] KO Korean
- [ ] TL Tagalog
- [ ] HY Armenian
- [ ] JA Japanese
- [ ] PS Persian
- [ ] PA Punjabi
- [ ] LO Khmer
- [ ] AR Arabic
- [ ] 03 White Hmong
- [ ] 28 Blue/Green Hmong

**Written Language Preference (Select only one)**

- [ ] EN English
- [ ] ES Spanish
- [ ] 20 Traditional Chinese
- [ ] VI Vietnamese
- [ ] KO Korean
- [ ] TL Tagalog
- [ ] HY Armenian
- [ ] IA Japanese
- [ ] PS Persian
- [ ] PA Punjabi
- [ ] LO Khmer
- [ ] AR Arabic
- [ ] 03 White Hmong
- [ ] 28 Blue/Green Hmong

## Spouse/Domestic Partner/Civil Union’s Language Preference

**Spoken Language Preference (Select only one)**

- [ ] EN English
- [ ] ES Spanish
- [ ] 12 Cantonese
- [ ] 14 Mandarin
- [ ] VI Vietnamese
- [ ] KO Korean
- [ ] TL Tagalog
- [ ] HY Armenian
- [ ] 28 Blue/Green Hmong

**Written Language Preference (Select only one)**

- [ ] EN English
- [ ] ES Spanish
- [ ] 20 Traditional Chinese
- [ ] VI Vietnamese
- [ ] KO Korean
- [ ] TL Tagalog
- [ ] HY Armenian
- [ ] 28 Blue/Green Hmong

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**Primary Applicant Name: ___________________________** **Enrollment Form ID: ___________________________**

*This application is not proof of coverage*
Dependent children are covered up to the end of the calendar month in which they reach age 26. Dependent children who have reached the end of the calendar month in which they turn age 26 can continue to be covered up to the end of the calendar year in which they reach age 30 provided the child is unmarried and does not have a dependent of their own AND is a resident of Florida OR a full-time or part-time student AND is not covered under any other health insurance policy or entitled to Medicare or Medicaid.

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

<table>
<thead>
<tr>
<th>Dependent's Last Name</th>
<th>First Name</th>
<th>M.I.</th>
<th>iTIN:</th>
<th>Social Security Number:</th>
</tr>
</thead>
</table>

Date of Birth: ____________________ Age: ____________ Single ☐ Married ☐ Male ☐ Female ☐

Select your choice of Primary Care Physician (PCP).

First Name: ____________________ Last Name: ____________________

PCP ID Number: ____________________

*Plans with this asterisk mean a PCP is required. If you do not select a PCP, one will be assigned for you.

Current Patient: ☐ Yes ☐ No

Does this person live at the same address as the Applicant? ☐ Yes ☐ No

If no, list address (Street, City, State, 9-digit ZIP Code and County):

__________________________ _______________ ____________________________

Dependent's Language Preference

Spoken Language Preference (Select only one)

☐ EN English ☐ ES Spanish ☐ 12 Cantonese ☐ 14 Mandarin ☐ VI Vietnamese ☐ KO Korean ☐ TL Tagalog

☐ HY Armenian ☐ JA Japanese ☐ PS Persian ☐ PA Punjabi ☐ LD Khmer ☐ AR Arabic ☐ 03 White Hmong

☐ 28 Blue/Green Hmong ☐ RU Russian ☐ Declines to State ☐ 99 Other ————————

Please Write In

Written Language Preference (Select only one)

☐ EN English ☐ ES Spanish ☐ 20 Traditional Chinese ☐ VI Vietnamese ☐ KO Korean ☐ TL Tagalog ☐ HY Armenian

☐ JA Japanese ☐ PS Persian ☐ PA Punjabi ☐ LD Khmer ☐ AR Arabic ☐ 03 White Hmong ☐ 28 Blue/Green Hmong

☐ RU Russian ☐ Declines to State ☐ 99 Other ————————

Please Write In

Dependent's Last Name

First Name: ____________________ M.I. | iTIN: | Social Security Number: |

Date of Birth: ____________________ Age: ____________ Single ☐ Married ☐ Male ☐ Female ☐

Select your choice of Primary Care Physician (PCP).

First Name: ____________________ Last Name: ____________________

PCP ID Number: ____________________

*Plans with this asterisk mean a PCP is required. If you do not select a PCP, one will be assigned for you.

Current Patient: ☐ Yes ☐ No

Does this person live at the same address as the Applicant? ☐ Yes ☐ No

If no, list address (Street, City, State, 9-digit ZIP Code and County):

__________________________ _______________ ____________________________

Dependent's Language Preference

Spoken Language Preference (Select only one)

☐ EN English ☐ ES Spanish ☐ 12 Cantonese ☐ 14 Mandarin ☐ VI Vietnamese ☐ KO Korean ☐ TL Tagalog

☐ HY Armenian ☐ JA Japanese ☐ PS Persian ☐ PA Punjabi ☐ LD Khmer ☐ AR Arabic ☐ 03 White Hmong

☐ 28 Blue/Green Hmong ☐ RU Russian ☐ Declines to State ☐ 99 Other ————————

Please Write In

Written Language Preference (Select only one)

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☐ JA Japanese ☐ PS Persian ☐ PA Punjabi ☐ LD Khmer ☐ AR Arabic ☐ 03 White Hmong ☐ 28 Blue/Green Hmong

☐ RU Russian ☐ Declines to State ☐ 99 Other ————————

Please Write In
**Primary Applicant Name: ___________________________**

**Enrollment Form ID: _____________________________**

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### Section D

**D1.** Are all enrollees residents of the United States? [ ] Yes [ ] No

If you answered “No” to the above question, provide names of non residents:

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**D2.** Do all enrollees reside within the State of Florida and within the service area of the selected benefit plan? [ ] Yes [ ] No

If you answered “No” to the above question, provide names of non residents:

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### Section E

**E1.** Does any applicant(s) have current health care coverage? [ ] Yes [ ] No

**E2.** If any applicant answered “Yes” to any of the above, please provide the following information:

- **Applicants Covered:** 
  - **Most Recent Coverage Start Date:** ____________  
  - **Termination Date:** ____________

**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 health coverage start date: (MM/DD/YYYY):** ____________  
  - **Termination date: (MM/DD/YYYY):** ____________

- **Applicant #2 Name:** 
  - **Most recent health coverage start date: (MM/DD/YYYY):** ____________  
  - **Termination date: (MM/DD/YYYY):** ____________

- **Applicant #3 Name:** 
  - **Most recent health coverage start date: (MM/DD/YYYY):** ____________  
  - **Termination date: (MM/DD/YYYY):** ____________

**E4.** Does any applicant(s) have current dental care coverage? [ ] Yes [ ] No

**E5.** If any applicant answered “Yes” to any of the above, please provide the following information:

- **Applicants Covered:** 
  - **Most Recent Coverage Start Date:** ____________  
  - **Termination Date:** ____________

**E6.** 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):** ____________

- **Applicant #2 Name:** 
  - **Most recent dental coverage start date: (MM/DD/YYYY):** ____________  
  - **Termination date: (MM/DD/YYYY):** ____________

- **Applicant #3 Name:** 
  - **Most recent dental coverage start date: (MM/DD/YYYY):** ____________  
  - **Termination date: (MM/DD/YYYY):** ____________

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### Section F

**F1.** Has any applicant smoked or used tobacco products on average for four (4) or more times per week within the past six months (includes chewing tobacco, cigarettes, cigars and pipes, excludes religious or ceremonial use of tobacco)? [ ] Yes [ ] No

If yes, list applicant name(s) and the last time they smoked or used tobacco products:

- **Name(s):** ____________________________________________  
  __________________________

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### Section G

**1.** I prefer to receive written correspondence regarding this application via email.

**2.** Please do not cancel other current health insurance coverage until written notification is received from Cigna Health and Life Insurance Company indicating that your application has been approved, and you and your dependents are in receipt of your ID cards.
### Section H. 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 only upon approval of your Application.*

**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 both for my initial payment and for ongoing 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.

<table>
<thead>
<tr>
<th>Account Number:</th>
<th>[ ] Checking</th>
<th>[ ] Saving</th>
</tr>
</thead>
<tbody>
<tr>
<td>Routing Number:</td>
<td>[ ] Checking</td>
<td>[ ] Saving</td>
</tr>
</tbody>
</table>

**Account Number:**

**Account Holder’s ZIP Code:**

**3-digit Code:**

**Any premium adjustment will automatically be charged to your account. Please be advised that the premium adjustment may reflect an increase.**

**Credit Card (Available for initial payment only)**
- [ ] VISA
- [ ] MASTERCARD

**Cardholder’s Name** – exactly as it appears on the card:

**Account Number:**

**Card Expiration Date:**

**Any premium adjustment will automatically be charged to your account. Please be advised that the premium adjustment may reflect an increase.**

**For Paper Application:**
- [ ] Paper check is attached
- [ ] 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 the EFT section above.
- [ ] 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 as provided in Section D of this application.

**For Online electronic submitted Application:**
- [ ] 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.
**Section I. Statement of Accountability** – To be completed when applicant cannot complete the application.

I, ___________________________ , personally read and completed this Enrollment 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 disclosed by: _______________________________________________________________

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

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

Today’s Date required

**Section J. Agent Section**

<table>
<thead>
<tr>
<th>Writing Agent Name:</th>
<th>Florida License Number:</th>
</tr>
</thead>
<tbody>
<tr>
<td>WILLIAM C. STAPLETON</td>
<td>P034032</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Street Address:</th>
<th>City:</th>
<th>State:</th>
</tr>
</thead>
<tbody>
<tr>
<td>35 NUTMEG DRIVE SUITE 220</td>
<td>TRUMBULL</td>
<td>CT</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Email Address:</th>
<th>Phone Number:</th>
</tr>
</thead>
<tbody>
<tr>
<td><a href="mailto:SALES@HEALTHPLANONE.COM">SALES@HEALTHPLANONE.COM</a></td>
<td>877-567-5267</td>
</tr>
</tbody>
</table>

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 Agent:

Please enter the name of the Agency/Agent that checks are to be made payable to if different from Writing Agent.

<table>
<thead>
<tr>
<th>Florida License Number:</th>
</tr>
</thead>
<tbody>
<tr>
<td>HEALTHPLANONE, LLC.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Street Address:</th>
<th>City:</th>
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<td>877-567-5267</td>
</tr>
</tbody>
</table>

Cigna Health and Life Insurance Company Sales Representative Last Name: ___________________________  First Name: ___________________________
### Section K. Conditions and Agreement/Authorization

1. I understand that any person who knowingly and with intent to injure, defraud, or deceive any insurer, files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

2. I authorize that payment be made under Part B of Medicare to Cigna Health and Life Insurance Company for medical and other services furnished by Cigna Health and Life Insurance Company for which it pays or has paid, if applicable.

3. I agree that in the event health services provided or covered are the primary responsibility of Medicare, workers’ compensation coverage, automobile medical payment coverage, or other payments source Cigna Health and Life Insurance Company may be authorized by applicable law to pursue, to fully inform Cigna Health and Life Insurance Company and execute such documents and provide such assistance as may be necessary to enable Cigna Health and Life Insurance Company to recover the value of services provided, arranged or covered.

4. I understand that I or my authorized representative is entitled to receive a copy of this authorization form.

5. 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 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.

<table>
<thead>
<tr>
<th>Applicat Signature:</th>
<th>Today's Date: (MM/DD/YYYY)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Custodial Parent or Legal Guardian Signature (for applicants under the age of 18):</td>
<td>Today's Date: (MM/DD/YYYY)</td>
</tr>
</tbody>
</table>

### Section L. Instructions

- The applicant is responsible for ensuring that the application is complete and truthful.
- Print clearly using black or blue ink.
- The application must be received by Cigna Health and Life Insurance Company within 30 days from the signature date.
- Coverage will become effective only if this application enrollment form is accepted and appropriate premium is enclosed.
- Do not cancel your current coverage until you have received notification from Cigna Health and Life Insurance Company.
- Effective dates are assigned to the 1st of the month. The next available effective date will be assigned, if not selected by the applicant.

### Section M. Contact Information

Please return the application enrollment form to the broker or submit to the address listed below:

Cigna Health and Life Insurance Company Individual and Family Plans
P.O. Box 30362
Tampa, FL 33630-3362
FAX #: 877.484.5927
www.Cigna.com

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) 8:00 AM - 8:00 PM ET
## Section N. Notice to Applicant Regarding Replacement of Accident and Sickness Insurance

According to your application, you intend to lapse or otherwise terminate existing accident and sickness insurance __________________________ (insert your policy number) you have with ________________________________ (insert Company name) and replace it with a policy to be issued by Cigna Health and Life Insurance Company. For your 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 interests 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 that all questions on the application concerning your medical/health history are truthfully and completely answered. 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 it should be carefully reviewed before being signed to be certain that all information has been properly recorded.

3. New policies may be issued at an older age than that used for issuance of your present policy; therefore, the cost of the new policy, depending upon the benefits, may be higher than you are paying for your present policy.

4. The renewal provisions of the new policy should be reviewed so as to make sure of your rights to periodically renew the policy.

The above “Notice to Applicant” was delivered to me on: _______________________

Witness (Writing Agent): ________________________________________________________________________________________

Primary Applicant Signature:  

Today’s Date: (MM/DD/YYYY)