Cigna Dental Plans

DENTAL BENEFIT	Cigna Dental 1500 Plan	
	CIGNA DPPO ADVANTAGE NETWORK Offers the most savings, 38%[1] national average.	**OUT-OF-NETWORK** Your out-of-pocket expenses will be higher; these providers have not agreed to offer Cigna customers our contracted or discounted fees. Example provided in chart A1.
Individual Calendar Year Deductible	$50 per person	
Family Calendar Year Deductible	$150 per family	
Calendar Year Maximum (For Class I, II, and III services)	$1,500 per person	
Lifetime Deductible (Separate per person for Orthodontia)	$50 per person	
Lifetime Maximum (Separate per person for Orthodontia)	$1,000 per person	
Payment levels	Based on provider's **contracted fees**	Based on provider's **standard fees** and the **MAC**
	CLASS I: PREVENTIVE/DIAGNOSTIC SERVICES	
Preventive/Diagnostic Services Waiting Period	Not applicable	
Preventive/Diagnostic Services Oral Exams, Routine Cleanings, Routine X-Rays, Sealants, Fluoride Treatment, Space Maintainers (non-orthodontic)	You pay $0 (No Charge)	You pay the difference between the provider's **standard fee** and **100% of the MAC**[2]
	CLASS II: BASIC RESTORATIVE SERVICES	
Basic Restorative Services Waiting Period	6-month waiting period[3]	
Basic Restorative Services Nonroutine X-Rays, Fillings, Routine Tooth Extraction, Emergency Treatment	You pay 20% of the provider's **contracted fee** (after deductible)	You pay the difference between the provider's **standard fee** and **80% of the MAC** (after deductible)
	CLASS III: MAJOR RESTORATIVE SERVICES	
Major Restorative Services Waiting Period	12-month waiting period[3]	
Major Restorative Services Periodontal (Deep Cleaning), Periodontal Maintenance, Crowns, Root Canal Therapy, Wisdom Tooth Extraction, Dentures/Partials, Bridges	You pay 50% of the provider's **contracted fee** (after deductible)	You pay the difference between the provider's **standard fee** and **50% of the MAC** (after deductible)
	CLASS IV: ORTHODONTIA	
Orthodontia Waiting Period	12-month waiting period[3]	
Orthodontia	You pay 50% of the provider's **contracted fee** (after separate lifetime deductible)	You pay the difference between the provider's **standard fee** and **50% of the MAC** (after separate lifetime deductible)

If you choose to visit a dentist out-of-network, you will pay the out-of-network benefit and the difference in the amount that Cigna reimburses for such services and the amount charged by the dentist, except for emergency services as defined in the policy. This is known as balance billing.

1. Based upon 1/1/2015–12/31/2015 National Average Charges projected by Cigna Dental to 7/1/2017. Fees vary by region.
2. Refer to the policy for more details.
3. NJ, VT & IL: 6-month waiting period for all classes; WV: 3-month waiting period for all classes; MO & RI: no waiting period for all Classes; You may be eligible to waive the waiting period for Classes II & III if you have continuous 12 months of prior coverage **from a valid dental insurance plan**. Orthodontia waiting period cannot be waived.

Cigna Dental Plans

PROCEDURE	Cigna Dental 1500 Plan FREQUENCY/LIMITATION
	CLASS I: PREVENTIVE/DIAGNOSTIC SERVICES
Oral Exams	1 per consecutive 6-month period
Routine Cleanings	1 routine prophylaxis or periodontal maintenance procedure per consecutive 6-month period (routine prophylaxis falls under Class 1; periodontal maintenance procedure falls under Class III)
Routine X-Rays	Bitewings: 1 set in any consecutive 12-month period. Limited to a maximum of 4 films per set
Sealants	1 treatment per tooth per lifetime. Payable on unrestored permanent bicuspid or molar teeth for participants less than age 14
Fluoride Treatment	1 per consecutive 12-month period for participants less than age 14
Space Maintainers (non-orthodontic)	Limited to non-orthodontic treatment for prematurely removed or missing teeth for participants less than age 14
	CLASS II: BASIC RESTORATIVE SERVICES
Nonroutine X-Rays	Full mouth or Panorex: 1 per consecutive 60-month period
Fillings	1 per tooth per consecutive 12-month period (applies to replacement of identical surface fillings only). No white/tooth colored fillings on bicuspid or molar teeth
Routine Tooth Extraction	Includes an allowance for local anesthesia and routine postoperative care
Emergency Treatment	Paid as a separate benefit only if no other service, except x-rays, is rendered during the visit
	CLASS III: MAJOR RESTORATIVE SERVICES
Periodontal (Deep Cleaning)	1 per quadrant per consecutive 36-month period
Periodontal Maintenance	Payable only if a consecutive 6-month period has passed since the completion of active periodontal surgery. 1 periodontal maintenance or routine prophylaxis procedure per consecutive 6-month period (periodontal maintenance procedure is Class III; routine prophylaxis is Class I)
Crowns	1 per tooth per consecutive 84-month period. Benefits are based on the amount payable for non-precious metals. No porcelain or white/tooth-colored material on molar crown or bridges. Replacement must be indicated by major decay. For participants less than age 16, benefits limited to resin or stainless steel
Root Canal Therapy	1 per tooth per lifetime
Wisdom Tooth Extraction	Includes an allowance for local anesthesia and routine postoperative care
Dentures and Partials	1 per arch per consecutive 84-month period
Bridges	1 per consecutive 84-month period. Benefits will be considered for the initial replacement of a necessary functioning natural tooth extracted while the person was covered under this plan
	CLASS IV: ORTHODONTIA
Orthodontia	The total amount payable for all expenses incurred for orthodontics during a person's lifetime will not be more than the orthodontia lifetime maximum

This summary contains highlights only.

Cigna Dental Plans

PLAN EXCLUSIONS AND LIMITATIONS

What is not covered by this plan
Excluded services

Covered expenses do not include expenses incurred for:

- Procedures which are not included in the policy.
- Procedures which are not necessary and which do not have uniform professional endorsement.
- Procedures for which a charge would not have been made in the absence of coverage or for which the covered person is not legally required to pay.
- Any procedure, service, supply or appliance, the sole or primary purpose of which relates to the change or maintenance of vertical dimension.
- Procedures, appliances or restorations whose main purpose is to diagnose or treat dysfunction of the temporomandibular joint (Services are covered in AR, MN, NM, NV, and VT).
- The alteration or restoration of occlusion.
- The restoration of teeth which have been damaged by erosion, attrition or abrasion.
- Bite registration or bite analysis.
- Any procedure, service or supply provided primarily for cosmetic purposes. Facings, repairs to facings or replacement of facings on crowns or bridge units on molar teeth shall always be considered cosmetic.
- The surgical placement of an implant body or framework of any type; surgical procedures in anticipation of implant placement; any device, index or surgical template guide used for implant surgery; treatment or repair of an existing implant; prefabricated or custom implant abutments; removal of an existing implant.
- Crowns, inlays, cast restorations, or other laboratory prepared restorations on teeth unless the tooth cannot be restored with an amalgam or composite resin filling due to major decay or fracture.
- Core build-ups.
- Replacement of a partial denture, full denture, or fixed bridge or the addition of teeth to a partial denture unless:
  - Replacement occurs at least 84 consecutive months after the initial date of insertion of the current full or partial denture; or
  - The partial denture is less than 84 consecutive months old, and the replacement is needed due to a necessary extraction of an additional functioning natural tooth while the person is covered under this plan (alternate benefits of adding a tooth to an existing appliance may be applied); or
  - Replacement occurs at least 84 consecutive months after the initial date of insertion of an existing fixed bridge (if the prior bridge is less than 84 consecutive months old, and replacement is needed due to an additional necessary extraction of a functioning natural tooth while the person is covered under this plan. Benefits will be considered only for the pontic replacing the additionally extracted tooth).
- The removal of only a permanent third molar will not qualify an initial or replacement partial denture, full denture or fixed bridge for benefits.
- The replacement of crowns, cast restoration, inlay, onlay or other laboratory prepared restorations within 84 consecutive months of the date of insertion.
- The replacement of a bridge, crown, cast restoration, inlay, onlay or other laboratory prepared restoration regardless of age unless necessitated by major decay or fracture of the underlying natural tooth.
- Any replacement of a bridge, crown or denture which is or can be made useable according to common dental standards.
- Replacement of a partial denture or full denture which can be made serviceable or is replaceable.
- Replacement of lost or stolen appliances.
- Replacement of teeth beyond the normal complement of 32.
- Prescription drugs.
- Any procedure, service, supply or appliance used primarily for the purpose of splinting.
- Athletic mouth guards.
- Myofunctional therapy.
- Precision or semi-precision attachments.
- Denture duplication.
- Separate charges for acid etch.
- Labial veneers (laminate).
- Porcelain or acrylic veneers of crowns or pontics on, or replacing the upper and lower first, second and third molars.
- Precious or semi-precious metals for crowns, bridges, pontics and abutments; crowns and bridges other than stainless steel or resin for participants under 16 years old.
- Treatment of jaw fractures and orthognathic surgery.
- Orthodontic treatment. Exclusion does not apply if the plan otherwise covers services for orthodontic treatment.
- Charges for sterilization of equipment, disposal of medical waste or other requirements mandated by OSHA or other regulatory agencies and infection control.
- Charges for travel time; transportation costs; or professional advice given on the phone.
- Temporary, transitional or interim dental services.
- Any procedure, service or supply not reasonably expected to correct the patient's dental condition for a period of at least three years, as determined by Cigna.
- Diagnostic casts, diagnostic models or study models.

Cigna Dental Plans

PLAN EXCLUSIONS AND LIMITATIONS

- Any charge for any treatment performed outside of the United States other than for emergency treatment (any benefits for emergency treatment which is performed outside of the United States will be limited to a maximum of $100 per consecutive 12-month period).
- Oral hygiene and diet instruction; broken appointments; completion of claim forms; personal supplies (water pick, toothbrush, floss holder); duplication of x-rays and exams required by a third party.
- Any charges, including ancillary charges, made by a hospital, ambulatory surgical center or similar facility.
- Services that are deemed to be medical services.
- Services for which benefits are not payable according to the "General Limitations" section.

General Limitations

No payment will be made for expenses incurred for you or any one of your dependents:

- For services not specifically listed as covered services in the policy.
- For services or supplies that are not dentally necessary.
- For services received before the effective date of coverage.
- For services received after coverage under this policy ends.
- For services for which you have no legal obligation to pay or for which no charge would be made if you did not have dental insurance coverage.
- For professional services or supplies received or purchased directly or on your behalf by anyone, including a dentist from any of the following:
  - Yourself or your employer.
  - A person who lives in the insured person's home, or that person's employer.
  - A person who is related to the insured person by blood, marriage or adoption, or that person's employer.
- For or in connection with an Injury arising out of, or in the course of, any employment for wage or profit.
- For or in connection with a sickness which is covered under any workers' compensation or similar law.
- For charges made by a hospital owned or operated by or which provides care or performs services for the United States Government, if such charges are directly related to a military-service-connected condition.
- Services or supplies received as a result of dental disease, defect or injury due to an act of war, declared or undeclared.
- To the extent that payment is unlawful where the person resides when the expenses are incurred.
- For charges which the person is not legally required to pay.
- For charges which would not have been made if the person had no insurance.
- To the extent that billed charges exceed the rate of reimbursement as described in the schedule.
- For charges for unnecessary care, treatment or surgery.
- To the extent that you or any of your dependents are in any way paid or entitled to payment for those expenses by or through a public program, other than Medicaid.
- For or in connection with experimental procedures or treatment methods not approved by the American Dental Association or the appropriate dental specialty society.
- Procedures that are a covered expense under any other dental plan which provides dental benefits.
- To the extent that benefits are paid or payable for those expenses under the mandatory part of any auto insurance policy written to comply with a "no-fault" insurance law or an uninsured motorist insurance law. Cigna will take into account any adjustment option chosen under such part by you or any one of your dependents.

Individual and Family Plans
Cigna Health and Life Insurance Company

All States - except AK, MA, MD, NC, NY & WA.
For AK, MA, MD, NC & NY, see state specific versions.

Cigna Dental Plans

PLAN IMPORTANT DISCLOSURES

Cigna Dental 1500 Plan includes a combination of insurance coverage and discounted services. The insurance coverage shall be only for the classes of service referred to in The Schedule of a purchased plan. Discounts are not available in Maryland, New York and Virginia.

Dental Plans are insured by Cigna Health and Life Insurance Company with network management services provided by Cigna Dental Health, Inc. Rates may vary based on age, family size, geographic location (residential zip code) and plan design.

All rates are subject to change upon 30 days' prior notice in AK, AL, AR, AZ, CO, CT, DC, DE, HI, IA, ID, IL, IN, KS, KY, MA, ME, MI, MN, MO, MT, ND, NE, NH, NJ, NM, OH, OK, OR, PA, RI, SD, TN, UT, VT, WI and WY, 31 days' prior notice in SC, 40 days' prior notice in MD, 45 days' prior notice in FL and 60 days' prior notice in CA, GA, MS, NV, TX, VA and WV. In LA rates are guaranteed for the initial 12-months of coverage, except if due to addition of a newly covered person, a change in age or geographic location, or a change in policy coverage. Thereafter, rates are subject to change upon 45 days' prior notice. In NC, dental rates are guaranteed for a 12-month period. **Dental plans apply waiting periods to covered basic (6-months), major (12-months) and orthodontic (12-months) dental care services.** In WV, a 3-month waiting period applies to covered basic, major and orthodontic dental care services. In IL, NJ, and VT, a 6-month waiting period applies to covered major and orthodontic dental care services. Waiting periods do not apply in MO and RI. In OH, a 12-month waiting period applies. Dental plans do not apply waiting periods to covered preventive/diagnostic services and temporomandibular joint services in AR, NM, NV, MN and VT. Some covered services are determined by age: Topical application of fluoride or sealant, space maintainers, and materials for crowns and bridges. If the plan covers replacement of teeth, there is no payment for replacement of teeth that are missing prior to coverage. In FL, payment limitation no longer applies after 24 months. In MD, NY and OH, payment limitation no longer applies after 12-months of continuous coverage.

Notice to Buyer: This policy provides dental coverage only. Review your policy carefully.

Dental preferred provider insurance policies (AL, CO, DE, CT, GA, IL, MA, MI, PA, UT, VA, WV and WY: HC-NOT11 et al., AK: HC-NOT53, et al., AR: HC-NOT36 et al., AZ: HC-NOT14, et al., CA: INDENTPOLCA0713 et al., DC: HC-NOT42, et al., FL: HC-NOT15 et al., HI, IA, MT & ND: HC-NOT11, et al., ID: HC-NOT51 et al., IN: HC-NOT23, et al., KS: HC-NOT49 et al., KY: HC-NOT44, et al., LA: INDDENTPOLLA0713, HC-NOT34 et al., MD: HC-NOT34, et al., ME: HC-NOT58, et al., MN: HC-NOT40, et al., MS: HC-NOT48 et al., MO: INDDENTPOLMO0713, NC: HC-NOT18, et al., NE HC-NOT47 et al., NH INDDENPOLNH0713, NJ: HC-NOT46, et al., NM: INDDENPOLNM0713, NV: HC-NOT39 et al., NY: INDENTPOLNY, OH: INDDENTPOLOH et al., OK: HC-NOT26 et al., OR: INDDENTPOLOR0713, RI HC-NOT35 et al., SC: HC-NOT19 et al., SD HC-NOT59 et al., TN: HC-NOT20 et al., TX: HC-NOT21 et al., VT HC-NOT56 et al., WI HC-NOT54 et al.) have exclusions, limitations, reduction of benefits and terms under which a policy may be continued in force or discontinued.

The policy may be cancelled by Cigna due to failure to pay premium, fraud, ineligibility, when the insured no longer lives in the service area, or if we cease to offer policies of this type or any individual dental plans in this state, in accordance with applicable law. You may cancel the policy, on the first of the month following our receipt of your written notice. We reserve the right to modify this policy, including policy provisions, benefits and coverages, consistent with state or federal law. This individual plan is renewable monthly or quarterly.

For costs, and additional details about coverage, contact Cigna Health and Life Insurance Company at 900 Cottage Grove Rd, Hartford, CT 06152 or call **866.GET.Cigna (866.438.2446)**.

The Dental Plans do not include pediatric dental services as required under the federal Patient Protection and Affordable Care Act (PPACA). This coverage is available in the insurance market. Please contact your insurance carrier, agent/producer, or the Health Insurance Marketplace if you wish to purchase PPACA compliant pediatric dental coverage.

888307 d 11/16

Primary Applicant Name_____
Application Form ID_____

Cigna Health and Life Insurance Company
Missouri 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:*
☐ 1st 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
☐ Cigna Dental Pediatric

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					☐ Male ☐ Female	
Custodial Parent or Legal Guardian Name (for applicants under the age of 18):					Relationship to Applicant:	
Spouse/Domestic Partner/Civil Union					☐ Male ☐ Female	
Dependent 1					☐ Male ☐ Female	
Dependent 2					☐ Male ☐ Female	
Dependent 3					☐ Male ☐ Female	
Dependent 4					☐ Male ☐ 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

_____
Preferred Household Email Address*:

Mailing Address (if different than Home Address):

_____
Street

_____
City State ZIP Code

_____ _____ _____
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

Inital 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* *Today's Date required*
(Excludes Parent Signature if Child Only Application)

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? ☐ 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:

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.