# CIGNA Dental PPO Enrollment Form

CIGNA Dental Health, Inc.
Insured dental plans underwritten by
Connecticut General Life Insurance Company

***Please print and thank you for providing this information***

**A**

☐ NEW ENROLL. ☐ CHANGE ☐ REINSTATE

AGENCY

EMPLOYEE NAME *(Last)* *(First)* *(M.I.)*

SOCIAL SECURITY NO.

EMPLOYEE DATE OF BIRTH (MM/DD/CCYY)

HOME PHONE ( )

WORK PHONE ( )

E-MAIL ADDRESS

OCCUPATION

ADDRESS *(Street)* *(City)* *(State)* *(Zip Code)*

GS/SES LEVEL (OR OTHER)

HOW DID YOU HEAR ABOUT WRIGHT USA?

**B**

| I WOULD LIKE COVERAGE FOR ME AND MY DEPENDENTS. *(Specify last name if different from yours)* Last Name / First Name / M.I. | DEPENDENT SOCIAL SECURITY NO. | DATE OF BIRTH MM DD CCYY | GENDER | FULL-TIME STUDENT? Yes No | START DATE OF CONTINUOUS DENTAL COVERAGE *(for CIGNA Dental PPO only)* *(Month, Day, Year)* | *(check one)* |
|---|---|---|---|---|---|---|
| Employee | | | ☐ M ☐ F | | | ☐ Add ☐ Cancel |
| Spouse | | | ☐ M ☐ F | | | ☐ Add ☐ Cancel |
| Dependent Relationship | | | ☐ M ☐ F | ☐ ☐ | | ☐ Add ☐ Cancel |
| Dependent Relationship | | | ☐ M ☐ F | ☐ ☐ | | ☐ Add ☐ Cancel |
| Dependent Relationship | | | ☐ M ☐ F | ☐ ☐ | | ☐ Add ☐ Cancel |

*Please submit proof of student or handicapped status for overage dependents.*
*The original effective date must be completed for each member in order for continuous coverage credit to be applied toward waiting period.*

**C**

**SIGNATURE -** The information provided above is true and correct to the best of my knowledge, and I accept the provisions on the reverse side of this form which I have read and understand.

EMPLOYEE'S SIGNATURE / DATE

**D**

**PAYMENT METHOD**

☐ **My premium payment is enclosed (Make check payable to: Wright USA)**

☐ **Charge my initial payment only to my credit card (renewal notices will be mailed):** ☐ Visa/Mastercard/Discover ☐ AMEX

Credit Card #: ______________ Exp. Date: ______________ Signature: ______________

☐ **I wish to pay by Electronic Funds Transfer (EFT):** ☐ Monthly ☐ Quarterly ☐ Annually

You may download the EFT form at www.WrightUSA.com Please mail your completed application and check made payable to WrightUSA, or application, EFT form and voided blank check to the address below.

706 Philadelphia Pike, Suite 1, Wilmington, DE 19809 Phone: 800.424.9801 Fax: 302.483.0230

**CIGNA Dental refers to the following operating subsidiaries of CIGNA Corporation: Connecticut General Life Insurance Company and CIGNA Dental Health, Inc., and its operating subsidiaries and affiliates. The CIGNA Dental PPO plan is underwritten or administered by Connecticut General Life Insurance Company with network management services provided by CIGNA Dental Health, Inc., and certain of its operating subsidiaries.**



**NOTE: Not all products are available for all clients or all states. Check your enrollment materials carefully to see what is offered for your group.**

## PROVISIONS

- I accept the coverage/insurance benefits provided by this group plan and authorize the processing of my enrollment in the coverage as indicated on this form. I authorize deduction from my earnings of the required contributions, if any, toward the cost of the coverage.
- I authorize payment of benefits to the participating provider.
- I authorize any participating office to release records and billing information concerning me or my dependents to CIGNA Dental Health and Connecticut General Life Insurance Company for purposes of plan administration or for the purpose of validating and determining benefits payable. I further authorize CIGNA Dental Health and Connecticut General Life Insurance Company to release any records or information concerning me or my dependents to its designee, for purposes of plan administration and customer service.
- California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance coverage. CIGNA Dental Health and Connecticut General Life Insurance Company do not require such tests in any state as a condition of obtaining dental coverage.

## FRAUD WARNING

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which *is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation. (In Florida, this is a felony of the third degree. In New York, the civil penalty is not to exceed five thousand dollars and the stated value of the claim for each such violation. *In Nebraska, "is" is changed to "may be").