Enrollment / Change Form

Insured and/or Administered by
Connecticut General Life Insurance Company
CIGNA HealthCare

Please complete form and click here to submit

A	☐ New Enrollment ☐ Open Enrollment	Hire Date Effective Date	Employer Name **University of Massachusetts Medical School**
	CIGNA Account No **3335254**	Type of Change ☐ Add Dependent(s) *(List Names in Section B)* ☐ Cancel Coverage ☐ Remove Dependents (*List Names in Section B*)	

B	Employee Name *(last)*	*(first)*	*(M.I.)*		Social Security No.
	Employee Date of Birth	Home Phone	Work Phone	Work E-Mail Address	UMass Employee ID #
	Address *(Street)*	*(City)*	*(State)*	*(Zip Code)*	

Last Name	First Name	Date of Birth	Gender	
Spouse (specify last name if different from employee)		| |	☐ M ☐ F	
Dependent (specify last name if different from employee)		| |	☐ M ☐ F	
Dependent (specify last name if different from employee)		| |	☐ M ☐ F	
Dependent (specify last name if different from employee)		| |	☐ M ☐ F	
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Dependent (specify last name if different from employee)		| |	☐ M ☐ F	
Dependent (specify last name if different from employee)		| |	☐ M ☐ F	

C	Coverage Level ☐ INDIVIDUAL ☐ FAMILY	D	Dental Options ☐ BASIC Dental PPO Plan (Code - DPPOB) ☐ FACULTY/EXECUTIVE Dental PPO Plan (Code - DPPOF) ☐ PLUS Dental PPO Plan (Code - DPPOP)

	Signature – The information provided above is true and correct to the best of my knowledge.	
E	Employee's Signature/ Date	Employer's Signature / Date