Retiree Dental Choice 1 Enrollment Application

Agent #: ______________

For Office Use Only

Effective Date:

Retirement Date:

Type of Enrollment:
☐ New ☐ Change ☐ Reinstatement

Complete this section to apply for Member coverage

Name: ____________________ Sex: ☐ Male ☐ Female

Address: ____________________ City: ____________________ State: ________ Zip: ____________

Email Address: ____________________ Phone Number: (_________) ____________________

Date of Birth: ____________________ Social Security #: ____________________

Complete this section to add Spouse and/or Dependent coverage

SPOUSE

Name: ____________________ Relationship to Member: ____________________

Address: ____________________ City: ____________________ State: ________ Zip: ____________

Sex: ☐ Male ☐ Female Date of Birth: ____________________ Social Security #: ____________________

DEPENDENT

Name: ____________________ Relationship to Member: ____________________

Address: ____________________ City: ____________________ State: ________ Zip: ____________

Sex: ☐ Male ☐ Female Date of Birth: ____________________ Social Security #: ____________________

Complete this section for All pERSon S to be covered

Insured name	**Dental Office Selction** (6 digit code found on provider list) *Primary Selection*	*Secondary Selection*

Sign and Date

I accept the coverage/insurance benefits provided by this group dental plan and authorize the processing of my enrollment in the dental coverage as indicated on this form.

I authorize payment of dental benefits to the provider of dental care.

I authorize any participating dental office to release dental 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 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 tests in any state as a condition of obtaining dental coverage.

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 insurance fraud. (In Florida, this is a felony of the third degree).

I am a CSEA Retiree Member and hereby enroll in the CSEA Retiree Dental Choice 1 Program. I have read and accept the provisions above.

Signature: ________________________________ **Date**: ____________________

Sign Here to Apply for CHOICE ONE

Must turn over to select payment method