# Dental Insurance Enrollment/Change Form

CIGNA
A Business of Caring.

***INSTRUCTIONS:*** *Top box to be completed by the Employer/Plan Sponsor. Remainder to be completed by the Employee.*

| **Name of Employer/Plan Sponsor:** | **Group/Plan:** | **Agency/Department Name:** | **Agency/Department Number:** |
|---|---|---|---|
| North Dakota Public Employees Retirement System | **3328472** | | |

| **This change is due to:** | | | **Effective Date of Coverage or Change:** |
|---|---|---|---|
| ☐ Initial Eligibility Following Hire<br>☐ Annual Enrollment<br>☐ Late Entrant due to Change in Family Status*<br>☐ Change Agency from_____to_____ | ☐ Address Change<br>☐ Add Dependent<br>☐ Delete Dependent | ☐ Cancel Coverage<br>☐ Loss of Other Coverage<br>☐ Termination<br>☐ Retirement | |

* A late entrant is an individual who is first enrolling for dental coverage after the first available opportunity.

| Employee Name *(last, first, middle initial)* | ☐ Female<br>☐ Male | Date of Birth | Social Security # |
|---|---|---|---|
| Employee Address *(street address, city, state, zip code)* | ☐ Single ☐ Married<br>☐ Divorced ☐ Widowed<br>☐ Legally Separated | Telephone<br>Work<br>Home | |

## Elect or Decline Coverage

| | | | | |
|---|---|---|---|---|
| **Elect Dental Coverage** | ☐ **Employee Only** | ☐ **Employee + Spouse** | ☐ **Employee + Child(ren)** | ☐ **Employee + Family** |
| **Waive Dental Coverage** | **IF YOU DO NOT WANT COVERAGE, COMPLETE THIS SECTION.** I have been given an opportunity to apply for Group Dental Insurance and have decided waive coverage for:<br>(check all that apply) ☐ myself ☐ spouse only ☐ child(ren) only ☐ myself and entire family | | | |

## Dependent Information *Complete for covered spouse and each covered child. Attach separate sheet if more room is needed.*

| Dependent Name *(last, first, middle initial)* | Relationship to Employee | Gender (F or M) | Date of Birth | Marital Status* | Child Status** | Add or Delete |
|---|---|---|---|---|---|---|
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* For Marital Status, enter one of the following: Single, Married, Divorced, Widowed, Legally Separated.
** For Child Status, indicate "S" if full-time student or "H" if handicapped, or leave blank if neither.

## Other Dental Coverage Information *Complete if you and/if any dependent have dental coverage with another insurer or carrier.*

| Employee/Dependent Name *(last, first, middle initial)* | Name and Address of Other Dental Insurer/Carrier | Policy/Plan Number | Effective Date | Other Dental Coverage Type |
|---|---|---|---|---|
| | | | | ☐ Single<br>☐ Family |
| | | | | ☐ Single<br>☐ Family |

**READ THIS INFORMATION CAREFULLY AND THEN SIGN AND DATE BELOW↓**

- I authorize my employer to deduct from my wages the premium, if any, for the elected coverage.
- To the best of my knowledge and belief, the information I have provided on this form is correct.
- **I understand that any person who knowingly and with intent to defraud, submits an application or files a claim containing any materially false or misleading information, commits a fraudulent act, which is a crime.**
- I understand my coverage begins on the effective date assigned by CIGNA HealthCare, provided I am actively at work.

| Employee's Signature | Date Signed |
|---|---|
| | |

Enter your name, gender, date of birth, social security number, mailing address, marital status, and telephone numbers.

## Elect Coverage

Select the level of coverage. If electing Employee + Spouse, Employee + Child(ren), or Employee + Family, complete spouse and dependent coverage information. If you are adding or dropping a spouse or dependent, ensure that you check the appropriate box.

## Waive Coverage

Select who is waiving coverage.

## Other Dental Coverage

Indicate if you and/or any dependent have other dental coverage.

**You must sign and date this form for it to be valid.**