Cigna Dental & Vision Enrollment / Change Form

Insured and/or Administered by Cigna
Connecticut General Life Insurance Company
Cigna Health and Life Insurance Company

Please print and thank you for providing this information

A	Cigna Account No. 3316064	**Effective Date of Add/Change**	Employer Name City of Springfield, Massachusetts	Employer Address 36 Court Street, Room #18 Springfield, MA 01103
	☐ Open Enrollment ☐ New Enrollment ☐ Change ☐ Reinstate ☐ Cancel	**Type of Change** ☐ Add Dependent(s)* ☐ Remove Dependent(s)* ☐ Cancel Coverage *List names in Section B	**Branch Code** ☐ ACTIVE ☐ RETIREE	**Dental/Vision Benefit Option** ☐ **DENTAL PPO BASE** (DPO4/Base) ☐ **DENTAL PPO BUY-UP** (DPOB/Buy Up) ☐ **DHMO BUY-UP** (DHMO/Narrow Network) **Requires Dental Provider ID*

B	Employee Name *(last)*		*(first)*		*(M.I.)*	Employee ID Number	
	Employee Date of Birth	Home Phone	Work Phone	Home E-Mail Address			
	Address *(Street)*		*(City)*	*(State)*		*(Zip Code)*	
		Last Name	First Name	M.I.	SSN	Date of Birth	Gender / Dental Prov. ID (**DHMO Only**)
	Spouse (whom you wish to cover)						☐ M ☐ F
	Dependent (whom you wish to cover)						☐ M ☐ F
	Dependent (whom you wish to cover)						☐ M ☐ F
	Dependent (whom you wish to cover)						☐ M ☐ F
	Dependent (whom you wish to cover)						☐ M ☐ F

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