Primary Applicant Name_____
Enrollment Form ID_____

Cigna Health and Life Insurance Company
California Individual and Family Plan Enrollment Application / Change Form

Cigna medical products offered in CA are currently pending regulatory approval.

Our medical plans are only available in the following services areas/counties:
Southern California: Los Angeles, Orange, Riverside, San Bernardino, and San Diego
Northern California: San Francisco, Santa Clara, Alameda, San Mateo, Contra Costa

Section A. Type of Application

New Enrollment Application:
☐ Applicant Only ☐ Applicant and Dependent(s) ☐ *Child Only
*Must complete one application for each child. Applications containing multiple children will not be accepted.

Existing Individual Plan Policy Member requesting a change in coverage:
☐ Add Family Member(s) or ☐ Request Plan Change
Subscriber Name:_____ Subscriber ID:_____

Requested Effective Date*:
☐ 1st of the Month of_____

Effective dates are assigned to the 1st of the month.
Cigna Health and Life Insurance Company will assign the next available effective date if not selected by the applicant.

**Requested Effective Date cannot be greater than 60 days after the Signature Date. No Effective Dates will be assigned prior to or on the Signature Date without a qualifying life event which allows same day coverage.*

Section B. Enrollment Criteria

Applications are accepted during annual open enrollment period or when an applicant experiences a Qualifying (Triggering) Life Event. Please select the applicable enrollment reason.

☐ Annual Open Enrollment

☐ Special Enrollment Period *(Select the qualifying event below).*

To apply for Special Enrollment Period an applicant must experience a Qualifying (Triggering) Life Event and has 60 days from the date of that event, (including the date of the actual event) to apply for coverage. Triggering events do not include loss of coverage due to failure to make premium payments on a timely basis, including COBRA premiums prior to expiration of COBRA coverage; and situations allowing for a rescission under federal law. Please select the applicable qualifying event reason(s) and date(s) below in order to determine your effective date and plan eligibility. Valid documentation will be required to be submitted for all Special Enrollment events.

- ☐ An eligible individual, and any dependent(s), loses his or her minimum essential coverage for reasons other than the reasons stated above
- ☐ An eligible individual gained or became a dependent through marriage or civil union
- ☐ An eligible individual gained or became a dependent through birth, adoption, or placement for adoption, or placement in foster care
- ☐ An eligible individual experienced an error in enrollment
- ☐ An eligible individual or enrollee made a permanent move and new coverage is available
- ☐ An eligible individual and his or her dependent(s) lose employer-sponsored health plan coverage due to involuntary termination of employment for reasons other than misconduct, or due to a reduction in work hours
- ☐ An eligible dependent spouse or child loses coverage under an employer-sponsored health plan due to employee's becoming entitled to Medicare, divorce or legal separation of the covered employee, and death of the covered employee
- ☐ An eligible individual loses his or her dependent child status under a parent's employer-sponsored health plan
- ☐ An eligible individual is mandated to be covered as a dependent pursuant to a valid court order, including child support
- ☐ An eligible individual was receiving services from a contracting provider under another health benefit plan, for an acute condition, a serious chronic condition, a pregnancy, a terminal illness, the care of a newborn child between birth and 36 months of age, and a surgery or other procedure that is scheduled to occur within 180 days of the provider's termination date from the health benefit plan and that provider is no longer participating in the health benefit plan
- ☐ An eligible individual is a member of the reserve forces of the United States military returning from active duty or a member of the California National Guard returning from active duty service

For any Special Enrollment Period reason, provide:
Name(s): _____ and Event Date(s): _____

Section C. Benefit Plan Options

Select Desired Medical Benefit Plan:
☐ Cigna California Bronze
☐ Cigna California Silver
☐ Cigna California Gold
☐ Cigna California Platinum
☐ Cigna California HSA Bronze
☐ Cigna California PPO Bronze
☐ Cigna LocalPlusIn 6000
☐ Cigna LocalPlusIn HSA 2900
☐ Cigna LocalPlusIn 2250

Select Desired Dental Benefit Plan:
☐ Cigna Dental 1500
☐ Cigna Dental 1000
☐ Cigna Dental Preventive

Primary:	☐ Medical	☐ Dental
Spouse (or Domestic Partner):	☐ Medical	☐ Dental
Dependent 1:	☐ Medical	☐ Dental
Dependent 2:	☐ Medical	☐ Dental

Section D. Applicant, Spouse and Dependent Information

Applicant's Last Name: | First Name: | M.I. | iTIN: / Social Security Number:

Date of Birth (MM/DD/YYYY): | Age: | ☐ Single ☐ Married | ☐ Male ☐ Female | Select your choice of Primary Care Physician (PCP)
First Name: _____ Last Name: _____
PCP ID Number: _____
*Plans with this asterisk mean a PCP is required. If you do not select a PCP, one will be assigned for you.
Current Patient: ☐ Yes ☐ No

Is any applicant enrolled in Medicare? ☐ Yes ☐ No
If you answered "Yes" to the above question, provide names of Medicare enrollees:
_____
For these applicants, please stop here, they are not eligible to enroll in health coverage.

Is any applicant eligible for Medicare? ☐ Yes ☐ No
If you answered "Yes" to the above question, provide names of individual(s) eligible for Medicare:
_____

Custodial Parent or Legal Guardian Name (for applicants under the age of 18): | Relationship to Applicant:

Mailing Address – Home Address Required
_____
Street
_____
City County State
_____
ZIP Code (Please provide 9-digit ZIP Code)

Billing Address – If different than mailing address
_____
P.O. Box / Street
_____
City State
_____
ZIP Code

Home Phone Number: ( ) _____-_____
Cell Phone Number: ( ) _____-_____
Work Phone Number: ( ) _____-_____
Email Address:

Applicant's Language Preference
Spoken Language Preference (Select only one)

☐ EN English ☐ ES Spanish ☐ 12 Cantonese ☐ 14 Mandarin ☐ VI Vietnamese ☐ KO Korean ☐ TL Tagalog
☐ HY Armenian ☐ JA Japanese ☐ PS Persian ☐ PA Punjabi ☐ LO Khmer ☐ AR Arabic ☐ 03 White Hmong
☐ 28 Blue/Green Hmong ☐ RU Russian ☐ Declines to State ☐ 99 Other _____
Please Write In

Written Language Preference (Select only one)

☐ EN English ☐ ES Spanish ☐ 20 Traditional Chinese ☐ VI Vietnamese ☐ KO Korean ☐ TL Tagalog ☐ HY Armenian
☐ JA Japanese ☐ PS Persian ☐ PA Punjabi ☐ LO Khmer ☐ AR Arabic ☐ 03 White Hmong ☐ 28 Blue/Green Hmong
☐ RU Russian ☐ Declines to State ☐ 99 Other _____
Please Write In

Spouse/Domestic Partner's Last Name: | First Name: | M.I. | iTIN: / Social Security Number:

Date of Birth (MM/DD/YYYY): | Age: | ☐ Single ☐ Married | ☐ Male ☐ Female | Select your choice of Primary Care Physician (PCP)
First Name: _____ Last Name: _____
PCP ID Number: _____
*Plans with this asterisk mean a PCP is required. If you do not select a PCP, one will be assigned for you.
Current Patient: ☐ Yes ☐ No

Is any applicant enrolled in Medicare? ☐ Yes ☐ No
If you answered "Yes" to the above question, provide names of Medicare enrollees:
_____
For these applicants, please stop here, they are not eligible to enroll in health coverage.

Is any applicant eligible for Medicare? ☐ Yes ☐ No
If you answered "Yes" to the above question, provide names of individual(s) eligible for Medicare:
_____

Spouse/Domestic Partner's Language Preference
Spoken Language Preference (Select only one)

☐ EN English ☐ ES Spanish ☐ 12 Cantonese ☐ 14 Mandarin ☐ VI Vietnamese ☐ KO Korean ☐ TL Tagalog
☐ HY Armenian ☐ JA Japanese ☐ PS Persian ☐ PA Punjabi ☐ LO Khmer ☐ AR Arabic ☐ 03 White Hmong
☐ 28 Blue/Green Hmong ☐ RU Russian ☐ Declines to State ☐ 99 Other _____
Please Write In

Primary Applicant Name_____ Enrollment Form ID_____

Written Language Preference (Select only one)

☐ EN English ☐ ES Spanish ☐ 20 Traditional Chinese ☐ VI Vietnamese ☐ KO Korean ☐ TL Tagalog ☐ HY Armenian
☐ JA Japanese ☐ PS Persian ☐ PA Punjabi ☐ LO Khmer ☐ AR Arabic ☐ 03 White Hmong ☐ 28 Blue/Green Hmong
☐ RU Russian ☐ Declines to State ☐ 99 Other _____
Please Write In

Dependent children are covered up to age 26. Disabled children may be covered beyond age 26.
☐ Check here if you are providing names of additional dependents on an attached separate page.

Dependent's Last Name:	First Name:	M.I.	iTIN: Social Security Number:

Date of Birth (MM/DD/YYYY):	Age:	☐ Single ☐ Married	☐ Male ☐ Female	Select your choice of Primary Care Physician (PCP) First Name: _____ Last Name: _____ PCP ID Number: _____ *Plans with this asterisk mean a PCP is required. If you do not select a PCP, one will be assigned for you. Current Patient: ☐ Yes ☐ No

Is there a Qualified Medical Child Support Order (*QMCSO)? ☐ Yes ☐ No
*A medical child support order which creates or recognizes the existence of a child's right to receive medical benefits which the responsible parent is eligible for under a health plan.

Dependent's Language Preference
Spoken Language Preference (Select only one)

☐ EN English ☐ ES Spanish ☐ 12 Cantonese ☐ 14 Mandarin ☐ VI Vietnamese ☐ KO Korean ☐ TL Tagalog
☐ HY Armenian ☐ JA Japanese ☐ PS Persian ☐ PA Punjabi ☐ LO Khmer ☐ AR Arabic ☐ 03 White Hmong
☐ 28 Blue/Green Hmong ☐ RU Russian ☐ Declines to State ☐ 99 Other _____
Please Write In

Written Language Preference (Select only one)

☐ EN English ☐ ES Spanish ☐ 20 Traditional Chinese ☐ VI Vietnamese ☐ KO Korean ☐ TL Tagalog ☐ HY Armenian
☐ JA Japanese ☐ PS Persian ☐ PA Punjabi ☐ LO Khmer ☐ AR Arabic ☐ 03 White Hmong ☐ 28 Blue/Green Hmong
☐ RU Russian ☐ Declines to State ☐ 99 Other _____
Please Write In

Dependent's Last Name:	First Name:	M.I.	iTIN: Social Security Number:

Date of Birth (MM/DD/YYYY):	Age:	☐ Single ☐ Married	☐ Male ☐ Female	Select your choice of Primary Care Physician (PCP) First Name: _____ Last Name: _____ PCP ID Number: _____ *Plans with this asterisk mean a PCP is required. If you do not select a PCP, one will be assigned for you. Current Patient: ☐ Yes ☐ No

Is there a Qualified Medical Child Support Order (*QMCSO)? ☐ Yes ☐ No
*A medical child support order which creates or recognizes the existence of a child's right to receive medical benefits which the responsible parent is eligible for under a health plan.

Dependent's Language Preference
Spoken Language Preference (Select only one)

☐ EN English ☐ ES Spanish ☐ 12 Cantonese ☐ 14 Mandarin ☐ VI Vietnamese ☐ KO Korean ☐ TL Tagalog
☐ HY Armenian ☐ JA Japanese ☐ PS Persian ☐ PA Punjabi ☐ LO Khmer ☐ AR Arabic ☐ 03 White Hmong
☐ 28 Blue/Green Hmong ☐ RU Russian ☐ Declines to State ☐ 99 Other _____
Please Write In

Written Language Preference (Select only one)

☐ EN English ☐ ES Spanish ☐ 20 Traditional Chinese ☐ VI Vietnamese ☐ KO Korean ☐ TL Tagalog ☐ HY Armenian
☐ JA Japanese ☐ PS Persian ☐ PA Punjabi ☐ LO Khmer ☐ AR Arabic ☐ 03 White Hmong ☐ 28 Blue/Green Hmong
☐ RU Russian ☐ Declines to State ☐ 99 Other _____
Please Write In

D1. Do all enrollees reside within the State of California and within the service area of the selected benefit plan? ☐ Yes ☐ No
If you answered "No" to the above question, provide names of non residents:
_____

Cigna Health and Life Insurance Company Use Only:	Effective Date:

Section E. Current Coverage and Additional Prior Dental Coverage Information

To be completed when purchasing a Dental Plan.

E1. Does any applicant(s) have current dental care coverage? ☐Yes ☐No

E2. If any applicant answered "Yes" to any of the above, please provide the following information:

Applicants Covered: _____

Most Recent Coverage Start Date: _____ Termination Date: _____

E3. Does this information apply to all family members on this application? ☐Yes ☐No
If "No", please add additional coverage information in the space provided below.

Applicant #1 Name: _____

Most recent dental coverage start date: (MM/DD/YYYY): _____ Termination date: (MM/DD/YYYY): _____

Applicant #2 Name: _____

Most recent dental coverage start date: (MM/DD/YYYY): _____ Termination date: (MM/DD/YYYY): _____

Applicant #3 Name: _____

Most recent dental coverage start date: (MM/DD/YYYY): _____ Termination date: (MM/DD/YYYY): _____

California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance coverage. This means that a health insurance company cannot make you take an HIV test when you apply for health insurance and cannot use the results of an HIV test to decide if you qualify for coverage.

Section F. Important Information

1. ☐ I prefer to receive written correspondence regarding this application via email.

2. Please do not cancel other current health insurance coverage until written notification is received from Cigna Health and Life Insurance Company indicating that your application has been approved, and you and your dependents are in receipt of your ID cards.

Section G. Payment Method

NOTE: Electronic Funds Transfer - EFT (Automatic draft from a checking or savings account) and Credit Card are the only initial payment methods allowed for online or faxed applications. The accounts will be charged only upon approval of your Application.

Initial Premium Payment Method:

☐ Electronic Funds Transfer (EFT) ☐ Automatic Credit Card Payment ☐ Paper Check

Electronic Funds Transfer – EFT (Automatic draft from a checking or savings account)

☐ Yes, I am requesting EFT both for my initial payment and for ongoing monthly payments (no paper or electronic monthly billing statement will be issued).

☐ Yes, I am requesting EFT for my initial payment. I agree that I am responsible for initiating all subsequent electronic monthly payments. I am requesting monthly electronic bills (eBills) to be sent to my email account as provided in Section D of this application.

Initial Premium Payment method: ☐ Use this account for my initial and subsequent premium payments.

Account Number:_____ ☐ Checking ☐ Saving

Routing Number: ☐☐☐☐☐☐☐☐☐

Name of Bank:_____ Name(s) on Account:_____

For Subsequent Premium Payments (If you desire to use a different bank account):

Account Number:_____ ☐ Checking ☐ Saving

Routing Number: ☐☐☐☐☐☐☐☐☐

Name of Bank:_____ Name(s) on Account:_____

I authorize the Company (Cigna Health and Life Insurance Company) to make monthly withdrawals, in the amount of my monthly premium, from my bank account as identified on this form and authorize the banking facility (Bank) to charge such withdrawals to my account. This authority will remain in effect until the Company receives written notice from me that the authority is terminated. Such termination will be effective with respect to the next premium due following 21 days after the written notice is received by the Company. I understand that if for any reason a withdrawal is not honored by the Bank (including, but not limited to, insufficient funds or my direction to the Bank not to honor the withdrawal), my health care contract premium will be unpaid, and failure to pay my health care contract premium may result in termination for my health care contract, that I may be charged an administration fee in addition to my healthcare premium, and that this authorization will remain in place until cancelled and that any due or past due premiums may be withdrawn under this authorization. I understand and agree that termination of this authorization does not relieve me of responsibility for charges incurred under my health care contract. I agree to indemnify and hold harmless the Company and its affiliates and employees for any claims arising out of transfers or deductions from my account in accordance with this authorization.

Any premium adjustment will automatically be charged to your account. Please be advised that the premium adjustment may reflect an increase.

Credit Card (Available for initial payment only) ☐ VISA ☐ MASTERCARD

Cardholder's Name – exactly as it appears on the card:

Account Number:
☐☐☐☐-☐☐☐☐-☐☐☐☐-☐☐☐☐

Card Expiration Date:

Account Holder's ZIP Code: ____ ____ ____ ____ ____ – ____ ____ ____ ____ 3-digit Code: ____ ____ ____

Any premium adjustment will automatically be charged to your account. Please be advised that the premium adjustment may reflect an increase.

For Paper Application: ***Please check here:*** ☐ Paper check is attached or ☐ Credit card information provided.

Ongoing Payment Options if paying by paper check or credit card for initial payment (please select one option only)

☐ **Monthly Paper Bill:** Yes, I am submitting a paper check (or have selected the credit card option) for my initial payment. I will submit a check for my ongoing monthly payments.

☐ **EFT Draft:** Yes, I am submitting a paper check for my initial payment (or have selected the credit card option) and I am requesting recurring automatic EFT drafts for ongoing monthly payments. (No paper or electronic monthly or quarterly billing statements will be issued.) *Please complete the EFT section above.*

☐ **Monthly Electronic Bill (eBill):** Yes, I am submitting a paper check (or have selected the credit card option) for my initial payment and agree that I am responsible for initiating all subsequent electronic monthly payments. I am requesting monthly electronic bills (eBills) to be sent to my email account provided in Section D of this application.

For Online electronic submitted Application:
Ongoing Payment Options if Credit Card Option was selected for initial payment (please select one option only).

☐ **EFT Draft:** Yes, I agree to recurring automatic EFT drafts for my ongoing monthly payments. (No paper or electronic monthly billing statement will be issued.) Please complete the EFT section above.

☐ **Monthly Electronic Bill (eBill):** Yes, I agree that I am responsible for initiating my ongoing electronic monthly payments. I am requesting monthly electronic bills (eBills) to be sent to my email account as provided in Section D of this application.

Section H. Statement of Accountability – *To be completed when applicant can not complete the application.*

I, _____, personally read and completed this Enrollment Application Form for the Applicant named below because:

☐ Applicant does not read English ☐ Applicant does not speak English ☐ Applicant does not write English

☐ Other (explain):_____

I personally translated the contents of this application disclosed by:

_____

I also personally translated and fully explained the Conditions and Agreement Section:

_____ _____

Signature of Translator *required* (*Excludes Parent Signature if Child Only Application*) | Today's Date *required*

Section I. Producer Section

Writing Producer Name:	Producer Code:	National Producer Number:
Street Address:	City:	State: ZIP Code:
Email Address:		
Phone Number:		

Attestation of Assistance:
For purposes of California Insurance Code §10119.3, as defined in the California Code of Regulations §2274.76, assisting an applicant in submitting an application for health insurance to a health insurer includes: (1) providing information or advice or answering the applicant's questions about any aspect of the application or it's submission, (2) providing information or advice or answering any of the applicant's questions about health insurance coverage sought by the applicant or (3) entering information directly into or onto the application.

Did you assist the above mentioned applicant? ☐ Yes ☐ No

If "Yes", are you aware of any information about your client not disclosed on this application? ☐ Yes ☐ No

If "Yes", please explain: _____

To the best of my knowledge, the information on the application is complete and accurate. I have explained to the applicant, in easy-to-understand language, the risk to the applicant of providing inaccurate information and the applicant understood the explanation. I understand that, if any portion of this statement by me is false, I may be subject to civil penalties of up to $10,000.

I verify that the application was completed by the applicant unless otherwise noted in the Statement of Accountability

Signature of Writing Producer:	Date:
Please enter the name of the Agency/Producer that checks are to be made payable to if different from Writing Producer.	Producer Code:

Street Address:	City:	State: ZIP Code:
Email Address:		
Phone Number:		
Cigna Health and Life Insurance Company Sales Representative Last Name:		First Name:

Section J. Instructions

- The applicant is responsible for ensuring that the application is complete and truthful.
- Print clearly using black or blue ink.
- The application must be received by Cigna Health and Life Insurance Company within 30 days from the signature date.
- Coverage will become effective only if this application enrollment form is accepted and appropriate premium is enclosed.
- Do not cancel your current coverage until you have received notification from Cigna Health and Life Insurance Company.
- Effective dates are generally assigned to the 1st of the month. The next available effective date will be assigned, if not selected by the applicant.

Section K. Conditions and Agreement/Authorization

1. I authorize that payment be made under Part B of Medicare to Cigna Health and Life Insurance Company for medical and other services furnished by Cigna Health and Life Insurance Company for which it pays or has paid, if applicable.
2. I agree that in the event health services provided or covered are the primary responsibility of Medicare, workers' compensation coverage, automobile medical payment coverage, or other payments source Cigna Health and Life Insurance Company may be authorized by applicable law to pursue, to fully inform Cigna Health and Life Insurance Company and execute such documents and provide such assistance as may be necessary to enable Cigna Health and Life Insurance Company to recover the value of services provided, arranged or covered.
3. I understand that I or my authorized representative is entitled to receive a copy of this authorization form.
4. I understand that information disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and will no longer be protected by federal privacy regulations.
5. If the applicant is a minor, I accept full legal and financial responsibility for the coverage and information provided on this application. (Court documents establishing guardianship must be submitted if the responsible adult is not the parent).

I acknowledge and agree that coverage shall become effective only after (a) this signed Application has been accepted, and (b) a contract has been issued by Cigna Health and Life Insurance Company.

I AGREE ON BEHALF OF MYSELF AND AS AUTHORIZED AGENT OR REPRESENTATIVE OF MY ELIGIBLE DEPENDENTS TO THE PROVISIONS CONTAINED ON THIS FORM.

All applicants 18 years and older must sign and date application. Applicants under the age of 18 require custodial parent or legal guardian signature acknowledging their understanding of and agreement to the conditions listed above.

The above statements are true and complete to the best of my knowledge and belief. I understand and agree that for my child, and/or me and my eligible dependents, these statements shall be the basis for determination of acceptance for coverage under my applicable Cigna Health and Life Insurance Company benefit plan. I acknowledge that Cigna Health and Life Insurance Company can't rescind my policy, or limit any provisions of my health insurance policy, once I am covered under the policy unless Cigna Health and Life Insurance Company can demonstrate that I have performed an act or practice constituting fraud or made an intentional misrepresentation of material fact as prohibited by the terms of the policy. After 24 months following the issuance of my policy, Cigna Health and Life Insurance Company will not be able to rescind the policy for any reason, can't cancel the policy, limit any of the provisions of the policy, or raise premiums on the policy due to any omissions, misrepresentations, or inaccuracies in the application form, whether willful or not. If my coverage is revoked I will receive 30 days advance notice prior to the effective date of the rescission that will explain the decision and my right to appeal. I also understand that I will be required to pay for any services that were covered while a member and that Cigna Health and Life Insurance Company will refund all amounts paid by me except amounts owed to Cigna Health and Life Insurance Company.

ARBITRATION

CIGNA HEALTH AND LIFE INSURANCE COMPANY USES BINDING ARBITRATION TO SETTLE DISPUTES, INCLUDING CLAIMS OF MEDICAL MALPRACTICE AND DISPUTES RELATING TO THE DELIVERY OF SERVICES UNDER THE POLICY. IT IS UNDERSTOOD THAT ANY DISPUTE AS TO MEDICAL MALPRACTICE, THAT IS AS TO WHETHER ANY MEDICAL SERVICES RENDERED UNDER THIS CONTRACT WERE UNNECESSARY OR UNAUTHORIZED OR WERE IMPROPERLY, NEGLIGENTLY OR INCOMPLETELY RENDERED, WILL BE DETERMINED BY SUBMISSION TO ARBITRATION AS PROVIDED BY CALIFORNIA LAW, AND NOT BY A LAWSUIT OR RESORT TO COURT PROCESS EXCEPT AS CALIFORNIA LAW PROVIDES FOR JUDICIAL REVIEW OR ARBITRATION PROCEEDINGS. THE PARTIES TO THIS CONTRACT, BY ENTERING INTO IT, ARE GIVING UP THEIR CONSTITUTIONAL RIGHT TO HAVE ANY DISPUTE DECIDED IN A COURT OF LAW BEFORE A JURY, AND INSTEAD ARE ACCEPTING THE USE OF ARBITRATION. IT IS UNDERSTOOD THAT THIS AGREEMENT TO ARBITRATE SHALL APPLY AND EXTEND TO ANY DISPUTE OR MEDICAL MALPRACTICE, RELATING TO THE DELIVERY OF SERVICE UNDER THE POLICY, AND TO ANY CLAIMS IN TORT, CONTRACT OR OTHERWISE, BETWEEN INDIVIDUAL(S) SEEKING SERVICE UNDER THE POLICY, WHETHER REFERRED TO AS A MEMBER, SUBSCRIBER, DEPENDENT, ENROLLEE OR OTHERWISE (WHETHER A MINOR OR AN ADULT), OR THE HEIRS-AT-LAW OR PERSONAL REPRESENTATIVES OF ANY SUCH INDIVIDUAL(S), AS THE CASE MAY BE, AND CIGNA HEALTH AND LIFE INSURANCE COMPANY (INCLUDING ANY OF THEIR AGENTS, SUCCESSORS –OR PREDECESSORS-IN-INTEREST, EMPLOYEES OR PROVIDERS.)

FOR THOSE CASES OR DISPUTES FOR MEDICAL MALPRACTICE WHICH THE TOTAL AMOUNT OF DAMAGES CLAIMED IS FIFTY THOUSAND DOLLARS ($50,000) OR LESS, THE PARTIES WILL SELECT A SINGLE NEUTRAL ARBITRATOR WHO SHALL HAVE NO JURISDICTION TO AWARD MORE THAN FIFTY THOUSAND DOLLARS ($50,000). IF THE PARTIES ARE UNABLE TO AGREE ON THE SELECTION OF A SINGLE NEUTRAL ARBITRATOR, THE METHOD PROVIDED IN SECTION 1281.6 OF THE CODE OF CIVIL PROCEDURE SHALL BE UTILIZED. THE SELECTION OF THE SINGLE ARBITRATOR FOR MALPRACTICE CLAIMS ONLY IS NOT SUBJECT TO WAIVER BY THE POLICY.

Applicant Signature:	Today's Date: (MM/DD/YYYY)
Custodial Parent or Legal Guardian Signature (for applicants under the age of 18):	Today's Date: (MM/DD/YYYY)

Section L. Contact Information

Please return the application enrollment form to the broker or submit to the address listed below:

Cigna Health and Life Insurance Company Individual and Family Plans
P.O. Box 30362
Tampa, FL 33630-3362
FAX # 877.484.5927
www.cigna.com