CIGNA ENROLLMENT / CHANGE FORM

Group Number: *3211196*	**Effective Date:** ***0 7 / 0 1 / 2 0 2 3*** *(Return form to Heather Orosz, Benefits Office by May 31,2023)*
Employer Name: *Simsbury Public Schools*	**Employer Address:** *933 Hopmeadow St, Simsbury, CT 06070*
Employee Branch/Division/Class: *UNAFF – Unaffiliated / Nutrition Srvs / SEED / DCE*	

Choose Plan Type: *(Choose only one)*

Open Access Plus - OAP (PPO)	In-Network Only Open Access Plus – OAP-IN (HMO)	High Deductible Health Plan with Health Savings Account – HDHP/HSA	High Deductible Health Plan with Health Reimbursement Account – HDHP/HRA
☐	☐	☐	☐

(Please Print)

EMPLOYEE LAST NAME:		***EMPLOYEE FIRST NAME:***	***MI***	***SOCIAL SECURITY NUMBER***
EMPLOYEE DATE OF BIRTH *(MM-DD-YYYY)*	***HOME PHONE*** ( )	***WORK PHONE*** ( )	***HOME E-MAIL ADDRESS***	***EMPLOYEE ID NUMBER***
STREET ADDRESS:		***CITY***	***STATE***	***ZIP CODE***

I WOULD LIKE COVERAGE FOR ME AND MY DEPENDENTS
(Specify last name if different from yours)

LAST NAME, FIRST NAME, MI	**SOCIAL SECURITY NUMBER** *(Required)*	**DATE OF BIRTH** *(MM-DD-YYYY)*	**GENDER**
Employee			
Spouse			
*Dependent**			
*Dependent**			
*Dependent**			
*Dependent**			

EMPLOYEE'S SIGNATURE / DATE	**EMPLOYER'S SIGNATURE / DATE**

**Dependents – Dependents are covered under the medical plan up to age 26. If totally disabled prior to dependent eligibility end date, attach proof of disability for eligibility review.*