SHELBY COUNTY SCHOOLS

New Retiree Health Care Plan Enrollment/Change Form

(Please complete this form in its entirety)

Administered by
Connecticut General Life Insurance Company
Cigna HealthCare of Tennessee, Inc.

Cigna.

A

☐ NEW RETIREE ☐ ENROLL CHANGE PERIOD	EFFECTIVE DATE OF ADD/CHANGE/ CANCELLATION (MM/DD/CCYY)	SCS PLAN GROUP	CIGNA ACCOUNT NO.	BRANCH CODE
			3211484	

EMPLOYER NAME	EMPLOYER ADDRESS
SHELBY COUNTY SCHOOLS	160 S. HOLLYWOOD, MEMPHIS, TN 38112

TYPE OF CHANGE:

☐ Cancel Dependent(s)* ☐ Change to Single ☐ Other _____

☐ Cancel Coverage* ☐ Change to Retiree + One Dependent

* List Names in Section B

MEDICAL COVERAGE TIER
☐ RETIREE ONLY ☐ RETIREE + ONE ☐ RETIREE + FAMILY
☐ WAIVE MEDICAL

PRE-65 RETIREE (under age 65)
☐ OAP IN-Network Plus ☐ OAP Basic ☐ Choice Fund HRA

POST-65 RETIREE or Medicare eligible (over age 65)
☐ MEDICARE SURROUND & PART D PHARMACY PLAN
☐ MEDICARE ADVANTAGE COVERAGE

DENTAL COVERAGE TIER (MUST HAVE MEDICAL COVERAGE)
☐ RETIREE ONLY ☐ RETIREE + ONE ☐ RETIREE + FAMILY
☐ DPPO 1500 ☐ WAIVE DENTAL

VISION COVERAGE TIER (MUST HAVE MEDICAL COVERAGE)
☐ RETIREE ONLY ☐ RETIREE + ONE ☐ RETIREE + FAMILY
☐ VISION ☐ WAIVE VISION

B

RETIREE

RETIREE NAME *(Last)*	*(First)*	*(M.I.)*	SOCIAL SECURITY NO.

DATE OF BIRTH (MM/DD/CCYY)	GENDER	HOME PHONE	WORK PHONE	E-MAIL ADDRESS	PRIMARY CARE PHYSICIAN NAME	PRIMARY CARE PHYSICIAN ID
	☐M ☐F	( )	( )			

ADDRESS *(Street)*	*(City)*	*(State)*	*(Zip Code)*

DEPENDENT INFORMATION Last Name / First Name / M.I.	DEPENDENT SOCIAL SECURITY NO.	DEPENDENT PRIMARY CARE PHYSICIAN	DATE OF BIRTH MM DD CCYY	GENDER	DEPENDENT COVERAGES	SCS EMPLOYEE? Yes No	*(check one)*
Spouse		Name _____ ID _____		☐M ☐F	☐Medical ☐Dental ☐Vision	☐ ☐	☐Add ☐Cancel
Dependent * Relationship		Name _____ ID _____		☐M ☐F	☐Medical ☐Dental ☐Vision	☐ ☐	☐Add ☐Cancel
Dependent * Relationship		Name _____ ID _____		☐M ☐F	☐Medical ☐Dental ☐Vision	☐ ☐	☐Add ☐Cancel

*** DEPENDENTS -** Up to age 26. Adult children married or unmarried and living or not living with parent qualify for this coverage. If totally disabled prior to age 26, attach proof of disability for eligibility review.

C

OTHER HEALTH CARE COVERAGE:
Do you or your dependents have other health insurance under a group plan, HMO, or Medicare? ☐Yes ☐No *If yes, please provide the following:*

NAME OF PERSON COVERED	SOCIAL SECURITY NO.	EFFECTIVE DATE	MEDICARE Part A	MEDICARE Part B	HIC # (MEDICARE ID NUMBER)	MEDICAID	OTHER INSURANCE CARRIER
			☐	☐		☐	☐
			☐	☐		☐	☐

D

SIGNATURE - I have read this form and certify that all statements contained are true and correct to the best of my knowledge. I understand any material misrepresentation will result in the cancellation of my coverage and the denial of claims plus reimbursement to the health plan of any benefit payments. I understand that if my coverage contains limitations on pre-existing conditions that these limitations will be stated in the plan. I accept the provisions on the reverse side of this form which I have read and understand.

RETIREE'S SIGNATURE	DATE

PROVISIONS

- "CIGNA HealthCare" refers to various operating subsidiaries of CIGNA Corporation. Products and services are provided by these subsidiaries and not by CIGNA Corporation. These subsidiaries include Connecticut General Life Insurance Company, Tel-Drug, Inc. and its affiliates, CIGNA Behavioral Health, Inc., Intracorp, and HMO or service company subsidiaries of CIGNA Health Corporation and CIGNA Dental Health, Inc.
- I agree, for myself and my dependents, that, in the event any health services provided are the primary responsibility of any other party by way of other group health coverage or by the act or omission of another person to fully inform the healthplan and will execute such assignments, liens or other documents which maybe necessary to enable the healthplan to recover the value of the services provided. I further agree that in the event I or any of my dependents collect benefits or damages from any other party who has primary responsibility for services provided by the healthplan, I will immediately reimburse the healthplan to the extent of services provided, to the extent permitted by state law.

FRAUD WARNING

It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

AUTHORIZATION TO DEDUCT CONTRIBUTIONS

I authorize deductions from my earnings of the required contributions, if any, toward the cost of the coverage. This authorization applies only if employee contributions are required.

SPECIAL PROVISION FOR EMPLOYERS WITH SECTION 125 PLANS

By allowing an individual to enroll in the Insurance Plan other than during the open enrollment period, CIGNA HealthCare or Connecticut General Life Insurance Company does not waive any terms of its contract. Further, by allowing an individual to enroll in the Insurance Plan other than during an open enrollment period, CIGNA HealthCare or Connecticut General Life Insurance Company does not thereby express any opinion regarding the appropriateness of the change under Section 125 of the Internal Revenue Code or the terms of the employer's Section 125 Plan.