

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.

A	<input type="checkbox"/> NEW RETIREE <input type="checkbox"/> ENROLL CHANGE PERIOD EMPLOYER NAME SHELBY COUNTY SCHOOLS TYPE OF CHANGE: <input type="checkbox"/> Cancel Dependent(s)* <input type="checkbox"/> Change to Single <input type="checkbox"/> Change to Retiree + One Dependent * List Names in Section B	EFFECTIVE DATE OF ADD/CHANGE/ CANCELLATION (MM/DD/CCYY) EMPLOYER ADDRESS 160 S. HOLLYWOOD, MEMPHIS, TN 38112	SCS PLAN GROUP 3211484	CIGNA ACCOUNT NO. / BRANCH CODE 3211484	MEDICAL COVERAGE TIER <input type="checkbox"/> RETIREE ONLY <input type="checkbox"/> WAIVE MEDICAL PRE-65 RETIREE (under age 65) <input type="checkbox"/> OAP IN-Network Plus <input type="checkbox"/> OAP Basic <input type="checkbox"/> Choice Fund HRA POST-65 RETIREE or Medicare eligible (over age 65) <input type="checkbox"/> MEDICARE SURROUND & PART D PHARMACY PLAN <input type="checkbox"/> MEDICARE ADVANTAGE COVERAGE () PPO () HMO DENTAL COVERAGE TIER (MUST HAVE MEDICAL COVERAGE) <input type="checkbox"/> RETIREE ONLY <input type="checkbox"/> RETIREE + ONE <input type="checkbox"/> DPPO 1500 <input type="checkbox"/> WAIVE DENTAL VISION COVERAGE TIER (MUST HAVE MEDICAL COVERAGE) <input type="checkbox"/> RETIREE ONLY <input type="checkbox"/> RETIREE + ONE <input type="checkbox"/> WAIVE VISION
----------	--	--	----------------------------------	---	---

B	RETIREE NAME (Last) _____ (M.I.) _____ SOCIAL SECURITY NO. _____ DATE OF BIRTH (MM/DD/CCYY) _____ GENDER <input type="checkbox"/> M <input type="checkbox"/> F _____ WORK PHONE () _____ ADDRESS (Street) _____ (City) _____ (State) _____ (Zip Code) _____ PRIMARY CARE PHYSICIAN NAME _____ PRIMARY CARE PHYSICIAN ID _____ E-MAIL ADDRESS _____
----------	---

DEPENDENT INFORMATION	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 _____		<input type="checkbox"/> M <input type="checkbox"/> F	Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Add <input type="checkbox"/> Cancel
Dependent *		Relationship Name _____ ID _____		<input type="checkbox"/> M <input type="checkbox"/> F	Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Add <input type="checkbox"/> Cancel
Dependent *		Relationship Name _____ ID _____		<input type="checkbox"/> M <input type="checkbox"/> F	Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Add <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please provide the following: EFFECTIVE DATE _____ MEDICARE Part A _____ Part B _____ SOCIAL SECURITY NO. _____ HIC # (MEDICARE ID NUMBER) _____ NAME OF PERSON COVERED _____ 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.