# *Rocky Hill Enrollment / Change Form*

Employee's Must complete Sections B-E

Cigna.

| A | | | | |
|---|---|---|---|---|
| ☐ Open Enroll. ☐ Change<br>☐ New Enroll. ☐ Reinstate | Effective Date | Employer Name<br>**Rocky Hill Public Schools** | Employer Address<br>**P O Box 627, 761 Old Main Street Rocky Hill Connecticut 06067** | |
| Account Number<br>**3211192** | Division/Branch/Location/Class | Date of Hire | Branch Code | Medical Option **Dental Option** |

Type of Change

☐ Add Dependent(s)* Date:_____
☐ Cancel Employee Last Date of Coverage:_____
☐ Cancel Dependent(s)* Last Date of Coverage:_____
*List Name in Section B

☐ Address Change
☐ Transfer to COBRA
☐ 18 mos. ☐ 29 mos. ☐ 36 mos.

☐ Family Security Benefit/Surviving Spouse
☐ Retirement
☐ Other _____

**B**

Employee Name *(last)* *(first)* *(M.I.)* | Date of Birth | Social Security No.

Home Phone | Work Phone | Employee Identification Number

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

| | Last Name | First Name | M.I. | Relationship | Dependent SSN | Date of Birth | Gender | PCP ID Number | Coverage Selection |
|---|---|---|---|---|---|---|---|---|---|
| Employee | | | | | \| \| | \| \| | ☐ M ☐ F | | ☐ Medical ☐ Dental |
| Spouse | | | | | \| \| | \| \| | ☐ M ☐ F | | ☐ Medical ☐ Dental |
| Dependent | | | | | \| \| | \| \| | ☐ M ☐ F | | ☐ Medical ☐ Dental |
| Dependent | | | | | \| \| | \| \| | ☐ M ☐ F | | ☐ Medical ☐ Dental |
| Dependent | | | | | \| \| | \| \| | ☐ M ☐ F | | ☐ Medical ☐ Dental |

*DEPENDENTS – If a full time student and age 19 or over, attach proof verifying credit hours. If totally disabled prior to age 19, attach proof of disability for eligibility review.

**C**

Medical Options:
☐ POS ☐ OAP* ☐ HSA ☐ * *not available to all groups*

Dental Options:
☐ Dental PPO ☐ Additional Coverage (Para's Only)

**D**

Other Health Care Coverage
Do you or any of your dependents have other health insurance under a group plan? ☐ Yes ☐ No If yes, please provide the following:

| Other Insurance Name of person covered | Social Security No. | Effective Date | Medicare Part A | Medicare Part B | Medicaid | Carrier |
|---|---|---|---|---|---|---|
| 1. | | | ☐ | ☐ | ☐ | _____ |
| 2. | | | ☐ | ☐ | ☐ | _____ |

Signature – The information provided above is true and correct to the best of my knowledge, and I accept the provisions on the reverse side of this form which I have read and understood.

**E**

| Employee's Signature/ Date | Spouse's Signature/Date | Employer's Signature / Date |
|---|---|---|
| | | |

If married Spouse MUST SIGN