Application Instructions for Cigna Dental Application - DC 2017

1. Please print all pages of the application.
2. Complete all questions and sections of the applicaton. Please write legibly.
3. Complete the fax cover letter and application and fax or mail to Virginia Medical Plans. If you do not have access to a fax machine, send the completed application to Virginia Medical Plans. You can also scan/email to jkatz@vamedicalplans.com.
4. When faxing or emailing application to us, initial payment must be made by EFT or Credit Card.

HELPFUL TIPS:

Here is a checklist of a few things that are commonly overlooked and are mandatory in processing your application.

- Select your preferred billing method.
- Sign and date the application.

IMPORTANT:

If you are mailing the applicaiton to us, don't forget to **enclose a check for the required payment made payable to Cigna** if you are not paying by EFT or credit card for the first month.

Mail completed applications and check to:

Virginia Medical Plans
Attn: New Enrollment
1404 Northpoint Glen Ct.
Herndon, VA 20170

Virginia Medical Plans will review your application for completeness and accuracy before submiting it to Cigna for processing. This may reduce the processing time because they cannot process unclear or incomplete applications until the missing information has been gathered.

Please contact us if you have any questions regarding the application or the application process. You may reach us at 703-707-8270 or toll free at 888-396-2341 or e-mail us at jkatz@vamedicalplans.com.

Norvax form #IN-1

VIRGINIA MEDICAL PLANS
FAMILY & BUSINESS HEALTH INSURANCE

Cigna

FAX COVER LETTER

(Please ignore this form if you do not have access to a fax machine.)

**Please FAX this cover letter with the completed application to:
Virginia Medical Plans
FAX# 888-514-4258

Dear Virginia Medical Plans,
Please accept my completed application for submittal and contact me to confirm receipt of this application

Name

E-mail

Date

Time

☐ Please contact me at this phone number _____ after you have reviewed my application for completeness and accuracy.

☐ I will contact Virginia Medical Plans at 703-707-8270 or toll free at 888-396-2341 to verify receipt of my application.

Norvax form #CS-1

Primary Applicant Name_____
Application Form ID_____

Cigna Health and Life Insurance Company

District of Columbia Application for Dental Insurance

Section A. Dental Coverage Options:

1. Select who the coverage is for:

☐ Primary Applicant Only ☐ Primary Applicant and Dependent(s) ☐ Child(ren) Only

2. Select what coverage applicant(s) is/are applying for:

☐ New Dental Coverage ☐ Add Family Member(s) to existing dental policy ☐ Add dental coverage to existing medical policy

☐ Request Plan Change ☐ Reinstatement

Policyholder's Name: _____ ID Number: _____

3. Select Requested Effective Date:*

☐ 1st of the Month of _____

*Next available effective date will be assigned if not selected by the applicant.

Section B. Benefit Plan Option:

☐ **Cigna Dental Preventive**
☐ **Cigna Dental 1000**
☐ **Cigna Dental 1500**

Section C. Applicant(s) applying for coverage: Dependent children are eligible for coverage up to age 26.

Last Name	First Name	M.I.	Age	Date of Birth (MM/DD/YYYY)	Gender	Social Security Number
Primary Applicant					☐ Male ☐ Female	
Custodial Parent or Legal Guardian Name (for applicants under the age of 18):					Relationship to Applicant:	
Spouse/Domestic Partner/Civil Union					☐ Male ☐ Female	
Dependent 1					☐ Male ☐ Female	
Dependent 2					☐ Male ☐ Female	
Dependent 3					☐ Male ☐ Female	
Dependent 4					☐ Male ☐ Female	

☐ Check here if you are providing names of additional dependents on an attached separate page.

Section D. Primary Applicant's Information:

Home Address Required:

_____
Street

_____
City State ZIP Code

_____
Preferred Household Email Address*:

Mailing Address (if different than Home Address):

_____
Street

_____
City State ZIP Code

_____ _____ _____
Cell Phone Home Phone Work Phone

*By providing your e-mail address, you agree to receive electronic communications about your application status, enrollment and Cigna Health and Life Insurance Company health benefit plans, products and services.

Primary Applicant's marital status: ☐ Married ☐ Single

Section E. Prior / Current Coverage Information

E1. Do you have prior or current dental coverage? ☐ Yes ☐ No

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

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

Name of prior or current dental plan carrier: _____ Policy Number: _____

Type of prior or current dental policy: ☐ Discount dental plan ☐ Preventive only dental plan ☐ Full coverage dental plan
☐ Other (please explain) _____

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) _____

Name of prior or current dental plan carrier: _____ Policy Number: _____

Type of prior or current dental policy: ☐ Discount dental plan ☐ Preventive only dental plan ☐ Full coverage dental plan
☐ Other (please explain) _____

Applicant #2 Name: _____

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

Name of prior or current dental plan carrier: _____ Policy Number: _____

Type of prior or current dental policy: ☐ Discount dental plan ☐ Preventive only dental plan ☐ Full coverage dental plan
☐ Other (please explain) _____

Applicant #3 Name: _____

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

Name of prior or current dental plan carrier: _____ Policy Number: _____

Type of prior or current dental policy: ☐ Discount dental plan ☐ Preventive only dental plan ☐ Full coverage dental plan
☐ Other (please explain) _____

E4. Do you have current medical coverage? ☐ Yes ☐ No

Section F. 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 upon approval of your Application.

Please select your payment method from the below options:

Premium Payment Frequency:

☐ Monthly

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 for both for my initial payment and for ongoing recurring 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.

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 premium withdrawals, in the amount of the premium payment noted above, 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, 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.

Credit Card

Name on Credit Card: _____ Expiration Date: _____

☐ VISA ☐ MASTERCARD

Card Number: ☐☐☐☐-☐☐☐☐ - ☐☐☐☐-☐☐☐☐

3-digit Code: _____ ZIP Code: _____

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 EFT Section.

☐ **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.

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

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.

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

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

I, _____, personally read and completed this 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 and, to the best of my knowledge, obtained and listed all the personal information disclosed by:

_____

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

_____ _____

Signature of Translator *required*
(Excludes Parent Signature if Child Only Application)

Today's Date required

Section H. Producer Information

Writing Producer Name: Jonathan Katz	Producer Code: 448481	
Street Address: 1404 Northpoint Glen Court	City: Herndon	State: VA ZIP Code: 20170
Email Address: jkatz@vamedicalplans.com		
Phone Number: 703-707-8270		
Are you aware of any information about your client not disclosed on this application? ☐ Yes ☐ No		
Did you see the proposed applicant at the time this application was completed? ☐ Yes ☐ No If "No", please explain:_____		
I verify that the application was completed by the applicant unless otherwise noted in the Statement of Accountability.		
Signature of Writing Producer:		Date: (MM/DD/YYYY)
Please enter the name of the Agency/Producer that checks are to be made payable to if different from Writing Producer: Katz Insurance Group LLC		Producer Code: 448481
Street Address: 1404 Northpoint Glen Court	City: Herndon	State: VA ZIP Code: 20170
Email Address: jkatz@vamedicalplalns.com		
Phone Number: 703-707-8270		
Sales Representative Last Name: Katz		First Name: Jonathan

Section I. Conditions and Agreement/Authorization

1. Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.
2. I understand that I or my authorized representative is entitled to receive a copy of this authorization form.
3. 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.
4. 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 by Cigna Health and Life Insurance Company, 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, INCLUDING THE PROVISIONS REGARDING THE COLLECTION, USE, AND DISCLOSURE OF PROTECTED HEALTH INFORMATION.

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 and agree that any misrepresentation or intentional omission may render this contract null and void from its date of issue in accordance with applicable law. If my coverage is revoked, I will receive written notice 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.

Primary 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 J. Instructions:

- **Mail or FAX this application to:**

Virginia Medical Plans
1404 Northpoint Glen Court
Herndon, VA 20170

Secure fax: 1-888-514-4258

- Fill in all information and print clearly using black or blue ink.
- The applicant is responsible for ensuring that the application is complete and truthful.
- Coverage will become effective only if this application is approved.
- Coverage is not guaranteed until you receive written notification from Cigna Health and Life Insurance Company. Do not cancel your current coverage until you have received written notification from Cigna Health and Life Insurance Company.
- 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.
- If you have questions about completing this application, please call

Virginia Medical Plans: 703-707-8270 or toll free 1-888-396-2341