VIRGINIA MEDICAL PLANS
FAMILY & BUSINESS HEALTH INSURANCE

Cigna

Application Instructions for Cigna Medical / Dental Application - 2017 Virginia

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 approval 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_____

Enrollment Form ID_____

Cigna Health and Life Insurance Company

Virginia Individual and Family Plan Enrollment Application / Change Form
900 Cottage Grove Road, Bloomfield, CT 06002
Individual and Family Major Medical Health and Dental Plans

Our medical plans are only available in the following coverage areas/counties:
Richmond: Amelia, Charles City, Chesterfield, Dinwiddie, Hanover, Henrico, Prince George, Sussex, Colonial Heights City, Hopewell City, Petersburg City, Richmond City
Northern: Alexandria City, Arlington, Clarke, Fairfax City, Fairfax, Falls Church City, Loudoun, Manassas City, Manassas Park City, Prince William, Stafford, Warren

Section A. Type of Application

New Enrollment Application:
☐ Applicant Only ☐ Applicant and Dependent(s) ☐ *Child Only
***Must complete one application for each child. Applications containing multiple children will not be accepted.**

Existing Individual Plan Policy Member requesting a change in coverage:
☐ Add Family Member(s) or ☐ Request Plan Change

Subscriber Name:_____ Subscriber ID:_____

Requested Effective Date:*
☐ 1st of the Month of _____

Effective dates are assigned to the 1st of the month. Cigna Health and Life Insurance Company will assign the next available effective date if not selected by the applicant.

** 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 without a triggering event which allows same day coverage.*

Section B. Enrollment Criteria

Applications are accepted during annual open enrollment period or when an applicant experiences a Triggering Event. Please select the applicable enrollment reason.

☐ Annual Open Enrollment

☐ Special Enrollment Period *(Select the triggering event below)*.

To apply for Special Enrollment Period an applicant must experience a Triggering Event and has 60 days from the date of that event, (including the date of the actual event) to apply for coverage. Triggering events **do not** include loss of coverage due to failure to make premium payments on a timely basis, including COBRA premiums prior to expiration of COBRA coverage; and situations allowing for a rescission under federal law. Please select the applicable triggering event reason(s) and date(s) below in order to determine your effective date and plan eligibility. Valid documentation will be required to be submitted for all Special Enrollment events.

☐ An eligible individual, and any dependent(s), loses his or her minimum essential coverage for reasons other than the reasons stated above

☐ An eligible individual gained or became a dependent through marriage

☐ An eligible individual gained or became a dependent through birth, adoption, or placement for adoption, or placement in foster care

☐ An eligible individual experienced an error in enrollment

☐ An eligible individual or enrollee made a permanent move and new coverage is available

☐ An eligible individual and his or her dependent(s) lose employer-sponsored health plan coverage due to involuntary termination of employment for reasons other than misconduct, or due to a reduction in work hours

☐ An eligible dependent spouse (or domestic partner) or child loses coverage under an employer-sponsored health plan due to employee's becoming entitled to Medicare, divorce or legal separation of the covered employee, and death of the covered employee

☐ An eligible individual loses his or her dependent child status under a parent's employer-sponsored health plan

☐ An eligible individual is mandated to be covered as a dependent pursuant to a valid court order, including child support

For any Special Enrollment Period reason, provide:

Name(s): _____ and Event Date(s): _____

Section C. Benefit Plan Options

EPO Plans
☐ **Cigna Connect HSA 5000
☐ **Cigna Connect 5750
☐ **Cigna US-VA Connect 6650
☐ **Cigna Connect 6400
☐ **Cigna Connect 2500
☐ **Cigna Connect 4500
☐ **Cigna Connect 2000
☐ **Cigna US-VA Connect 3500
☐ **Cigna Connect 1200

Select Desired Dental Benefit Plan:
☐ Cigna Dental Preventive
☐ Cigna Dental 1000
☐ Cigna Dental 1500

Primary:	☐ Medical	☐ Dental
Spouse (or Domestic Partner):	☐ Medical	☐ Dental
Dependent 1:	☐ Medical	☐ Dental
Dependent 2:	☐ Medical	☐ Dental

Section D. Applicant, Spouse/Domestic Partner and Dependent Information

Applicant's Last Name: | First Name: | M.I. | iTIN: / Social Security Number:

Date of Birth: | Age: | ☐ Single ☐ Married | ☐ Male ☐ Female | Select your choice of Primary Care Physician (PCP).
First Name: _____ Last Name: _____
PCP ID Number: _____
**Plans with this asterisk mean a PCP is required. If you do not select a PCP, one will be assigned for you.
Current Patient: ☐ Yes ☐ No

Is any applicant enrolled in Medicare? ☐ Yes ☐ No
If you answered "Yes" to the above question, provide names of Medicare enrollees: _____

Is any applicant eligible for Medicare, *due to age*? ☐ Yes ☐ No
If you answered "Yes" to the above question, provide names of individual(s) eligible for Medicare: _____

Custodial Parent or Legal Guardian Name (for applicants under the age of 18): | Relationship to Applicant:

Mailing Address – Home Address Required
Street
City County State
ZIP Code (Please provide 9-digit ZIP Code)

Billing Address – If different than mailing address
P.O. Box / Street
City State
ZIP Code

Home Phone Number: ( ) _____-_____
Cell Phone Number: ( ) _____-_____
Work Phone Number: ( ) _____-_____
Email Address:

Applicant's Language Preference
Spoken Language Preference (Select only one)

☐ EN English ☐ ES Spanish ☐ 12 Cantonese ☐ 14 Mandarin ☐ VI Vietnamese ☐ KO Korean ☐ TL Tagalog
☐ HY Armenian ☐ JA Japanese ☐ PS Persian ☐ PA Punjabi ☐ LO Khmer ☐ AR Arabic ☐ 03 White Hmong
☐ 28 Blue/Green Hmong ☐ RU Russian ☐ Declines to State ☐ 99 Other _____
Please Write In

Written Language Preference (Select only one)

☐ EN English ☐ ES Spanish ☐ 20 Traditional Chinese ☐ VI Vietnamese ☐ KO Korean ☐ TL Tagalog ☐ HY Armenian
☐ JA Japanese ☐ PS Persian ☐ PA Punjabi ☐ LO Khmer ☐ AR Arabic ☐ 03 White Hmong ☐ 28 Blue/Green Hmong
☐ RU Russian ☐ Declines to State ☐ 99 Other _____
Please Write In

Spouse/Domestic Partner's Last Name | First Name | M.I. | iTIN: / Social Security Number:

Date of Birth: | Age: | ☐ Single ☐ Married | ☐ Male ☐ Female | Select your choice of Primary Care Physician (PCP).
First Name: _____ Last Name: _____
PCP ID Number: _____
**Plans with this asterisk mean a PCP is required. If you do not select a PCP, one will be assigned for you.
Current Patient: ☐ Yes ☐ No

Is any applicant enrolled in Medicare? ☐ Yes ☐ No
If you answered "Yes" to the above question, provide names of Medicare enrollees: _____

Is any applicant eligible for Medicare, *due to age*? ☐ Yes ☐ No
If you answered "Yes" to the above question, provide names of individual(s) eligible for Medicare: _____

Spouse/Domestic Partner's Language Preference
Spoken Language Preference (Select only one)

☐ EN English ☐ ES Spanish ☐ 12 Cantonese ☐ 14 Mandarin ☐ VI Vietnamese ☐ KO Korean ☐ TL Tagalog
☐ HY Armenian ☐ JA Japanese ☐ PS Persian ☐ PA Punjabi ☐ LO Khmer ☐ AR Arabic ☐ 03 White Hmong
☐ 28 Blue/Green Hmong ☐ RU Russian ☐ Declines to State ☐ 99 Other _____
Please Write In

Primary Applicant Name_____ Enrollment Form ID_____

Written Language Preference (Select only one)

☐ EN English ☐ ES Spanish ☐ 20 Traditional Chinese ☐ VI Vietnamese ☐ KO Korean ☐ TL Tagalog ☐ HY Armenian
☐ JA Japanese ☐ PS Persian ☐ PA Punjabi ☐ LO Khmer ☐ AR Arabic ☐ 03 White Hmong ☐ 28 Blue/Green Hmong
☐ RU Russian ☐ Declines to State ☐ 99 Other _____
Please Write In

Dependent children are covered up to age 26.
☐ Check here if you are providing names of additional dependents on an attached separate page.

Applicant's Dependent Last Name	First Name	M.I.	iTIN: / Social Security Number:

Date of Birth:	Age:	☐ Single ☐ Married	☐ Male ☐ Female	Select your choice of Primary Care Physician (PCP). First Name: _____ Last Name: _____ PCP ID Number: _____ **Plans with this asterisk mean a PCP is required. If you do not select a PCP, one will be assigned for you. Current Patient: ☐ Yes ☐ No

Is there a Qualified Medical Child Support Order (*QMCSO)? ☐ Yes ☐ No
*A medical child support order which creates or recognizes the existence of a child's right to receive medical benefits which the responsible parent is eligible for under a health plan.

Dependent's Language Preference
Spoken Language Preference (Select only one)

☐ EN English ☐ ES Spanish ☐ 12 Cantonese ☐ 14 Mandarin ☐ VI Vietnamese ☐ KO Korean ☐ TL Tagalog
☐ HY Armenian ☐ JA Japanese ☐ PS Persian ☐ PA Punjabi ☐ LO Khmer ☐ AR Arabic ☐ 03 White Hmong
☐ 28 Blue/Green Hmong ☐ RU Russian ☐ Declines to State ☐ 99 Other _____
Please Write In

Written Language Preference (Select only one)

☐ EN English ☐ ES Spanish ☐ 20 Traditional Chinese ☐ VI Vietnamese ☐ KO Korean ☐ TL Tagalog ☐ HY Armenian
☐ JA Japanese ☐ PS Persian ☐ PA Punjabi ☐ LO Khmer ☐ AR Arabic ☐ 03 White Hmong ☐ 28 Blue/Green Hmong
☐ RU Russian ☐ Declines to State ☐ 99 Other _____
Please Write In

Applicant's Dependent Last Name	First Name	M.I.	iTIN: / Social Security Number:

Date of Birth:	Age:	☐ Single ☐ Married	☐ Male ☐ Female	Select your choice of Primary Care Physician (PCP). First Name: _____ Last Name: _____ PCP ID Number: _____ **Plans with this asterisk mean a PCP is required. If you do not select a PCP, one will be assigned for you. Current Patient: ☐ Yes ☐ No

Is there a Qualified Medical Child Support Order (*QMCSO)? ☐ Yes ☐ No
*A medical child support order which creates or recognizes the existence of a child's right to receive medical benefits which the responsible parent is eligible for under a health plan.

Dependent's Language Preference
Spoken Language Preference (Select only one)

☐ EN English ☐ ES Spanish ☐ 12 Cantonese ☐ 14 Mandarin ☐ VI Vietnamese ☐ KO Korean ☐ TL Tagalog
☐ HY Armenian ☐ JA Japanese ☐ PS Persian ☐ PA Punjabi ☐ LO Khmer ☐ AR Arabic ☐ 03 White Hmong
☐ 28 Blue/Green Hmong ☐ RU Russian ☐ Declines to State ☐ 99 Other _____
Please Write In

Written Language Preference (Select only one)

☐ EN English ☐ ES Spanish ☐ 20 Traditional Chinese ☐ VI Vietnamese ☐ KO Korean ☐ TL Tagalog ☐ HY Armenian
☐ JA Japanese ☐ PS Persian ☐ PA Punjabi ☐ LO Khmer ☐ AR Arabic ☐ 03 White Hmong ☐ 28 Blue/Green Hmong
☐ RU Russian ☐ Declines to State ☐ 99 Other _____
Please Write In

D1. Do all enrollees reside, live or work within Virginia and within the coverage area/counties of the selected benefit plan? ☐Yes ☐No

If you answered "No" to the above question, provide names of non residents:

_____

Section E. Current Coverage and Additional Prior Coverage Information

To be completed when purchasing a medical plan.

E1. Does any applicant(s) have current health care coverage? ☐Yes ☐No

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

Applicants Covered: _____

Most Recent Coverage Start Date: _____ Termination Date: _____

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 health coverage start date: (MM/DD/YYYY): _____ Termination date: (MM/DD/YYYY): _____

Applicant #2 Name: _____

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

Applicant #3 Name: _____

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

To be completed when purchasing a dental plan.

E4. Does any applicant(s) have current dental care coverage? ☐Yes ☐No

E5. If any applicant answered "Yes" to any of the above, please provide the following information:

Applicants Covered: _____

Most Recent Coverage Start Date: _____ Termination Date: _____

E6. 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): _____

Applicant #2 Name: _____

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

Applicant #3 Name: _____

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

E7. Do you intend to lapse or otherwise terminate existing health insurance and replace it with a policy to be issued by Cigna Health and Life Insurance Company?

☐Yes ☐No

Section F. Health Related Questions

F1. Has any applicant smoked or used tobacco products on average for four (4) or more times per week within the past six months (includes chewing tobacco, cigarettes, cigars and pipes, excludes religious or ceremonial use of tobacco)? ☐Yes ☐No

If yes, list applicant name(s) and the last time they smoked or used tobacco products:

Name(s): _____

Section G. Important Information

1. ☐ I prefer to receive written correspondence regarding this application via email.

2. Please do not cancel other current health insurance coverage until written notification is received from Cigna Health and Life Insurance Company indicating that your application has been approved, and you and your dependents are in receipt of your ID cards.

Section H. 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 only upon approval of your Application.

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 both for my initial payment and for ongoing 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.

Initial Premium Payment Method: ☐ Use this account for my initial and subsequent premium payments.

Account Number:_____ ☐ Checking ☐ Saving

Routing Number: ☐☐☐☐☐☐☐☐☐

Name of Bank:_____ Name(s) on Account:_____

For Subsequent Premium Payments (If you desire to use a different bank account):

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 monthly withdrawals, in the amount of my monthly premium, 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, that I may be charged an administration fee in addition to my healthcare premium, 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 unless the Company's actions were grossly negligent.

Any premium adjustment will automatically be charged to your account. Please be advised that the premium adjustment may reflect an increase.

Credit Card (Available for initial payment only) ☐ VISA ☐ MASTERCARD

Cardholder's Name – exactly as it appears on the card:

For Initial Premium Payment

Account Number: 3-Digit Code

☐☐☐☐-☐☐☐☐-☐☐☐☐-☐☐☐☐ ☐☐☐

Account Holder's ZIP Code: ____ ____ ____ ____ ____ – ____ ____ ____ ____

Card Expiration Date:

Any premium adjustment will automatically be charged to your account. Please be advised that the premium adjustment may reflect an increase.

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 the EFT section above.*

☐ **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.

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.

Primary Applicant Name_____ Enrollment Form ID_____

Section I. Statement of Accountability – *To be completed when applicant cannot complete the application.*

I, _____, personally read and completed this Enrollment 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 disclosed by:

_____

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

_____ _____

Signature of Translator *required* (*Excludes Parent Signature if Child Only Application*) | Today's Date *required*

Section J. Producer Section

Writing Producer Name: Jonathan Katz	Producer Code: 448481	
Street Address: 1404 Northpoint Glen Court	City: Herndon	State: 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? If "No", please explain:_____		☐ Yes ☐ No
I verify that the application was completed by the applicant unless otherwise noted in the Statement of Accountability.		
Signature of Writing Producer:		Date:
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@vamedicalplans.com		
Phone Number: 703-707-8270		
Cigna Health and Life Insurance Company Sales Representative Last Name: Katz		First Name: Jonathan

Section K. Contact Information

Please return the application enrollment form to the broker or submit to the address listed below:

Cigna Health and Life Insurance Company Individual and Family Plans
P.O. Box 30362
Tampa, FL 33630-3362
FAX # 877-484-5927
www.Cigna.com

Virginia Medical Plans
1404 Northpoint Glen Court
Herndon, VA 20170

OR fax securely to: 1-888-514-4258

Questions?
Call 1-888-396-2341
or 703-707-8270

If you have questions about completing this application, please call Cigna Health and Life Insurance Company at 1-866-GET-Cigna (1-866-438-2446) 8:00 AM - 8:00 PM ET

Section L. Instructions

- The applicant is responsible for ensuring that the application is complete and truthful.
- Print clearly using black or blue ink.
- The application must be received by Cigna Health and Life Insurance Company within 30 days from the signature date.
- Coverage will become effective only if this application enrollment form is accepted and appropriate premium is enclosed.
- Do not cancel your current coverage until you have received notification from Cigna Health and Life Insurance Company.
- Effective dates are generally assigned to the 1st or 15th of the month. The next available effective date will be assigned, if not selected by the applicant.

Section M. Conditions and Agreement/Authorization

1. I understand that any person who, with the intent to defraud or knowingly that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated state law.
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 an 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.

The undersigned applicant and the agent certify that the applicant has read, or had read to him, the completed application and that the applicant realizes that any false statement or misrepresentation in the application may result in the loss of coverage under the policy.

Insurance With Other Companies. If an insured person has coverage that provides the same benefits under this policy with another carrier (of which Cigna Health and Life Insurance Company has not received written notice of the coverage prior to the loss), the only liability Cigna Health and Life Insurance Company shall be responsible for is the amount which otherwise would have been payable under this policy. Payment will never exceed the total of the incurred expenses or the maximums shown in the schedule. Cigna Health and Life Insurance Company shall return promptly such portion of any premium paid as shall exceed the pro rata portion for the amount so determined.

The undersigned applicant and the agent, if applicable, certify that the applicant has read, or had read to him, the completed application and that the applicant realizes that any false statement or misrepresentation in the application may result in the loss of coverage under the policy.

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 N. Notice to Applicant (Complete this section ONLY if you are replacing an existing policy with a Cigna Health and Life Insurance Company policy)

NOTICE TO APPLICANT REGARDING REPLACEMENT OF ACCIDENT AND HEALTH INSURANCE

According to your application, you intend to lapse or otherwise terminate existing accident and health insurance and replace it with a policy to be issued by Cigna Health and Life Insurance Company. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy.

(1) You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.

(2) If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical/health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, reread it carefully to be certain that all information has been properly recorded.

The above "Notice to Applicant" was delivered to me on:

Date: (MM/DD/YYYY): _____

Applicant's Signature: _____