



Application Instructions for Cigna Dental Application

1. Please print all pages of the application.
2. Complete all questions and sections of the application. 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 application 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. Please note EFT or credit card is preferred.

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 submitting it to Cigna for processing. This may affect the processing time because Cigna 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.



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 or 703-783-5913

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

_____ 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.

Primary Applicant Name _____

Application Form ID _____

Cigna Health and Life Insurance Company Virginia 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 Elective 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 1500
 Cigna Dental 1000

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					<input type="checkbox"/> Male <input type="checkbox"/> Female	
Custodial Parent or Legal Guardian Name (for applicants under the age of 18):					Relationship to Applicant:	
Spouse/Domestic Partner					<input type="checkbox"/> Male <input type="checkbox"/> Female	
Dependent 1					<input type="checkbox"/> Male <input type="checkbox"/> Female	
Dependent 2					<input type="checkbox"/> Male <input type="checkbox"/> Female	
Dependent 3					<input type="checkbox"/> Male <input type="checkbox"/> Female	
Dependent 4					<input type="checkbox"/> Male <input type="checkbox"/> 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 intend to replace your current dental insurance with this policy? Yes No **If you answered yes, please see Section K.**

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 both for my initial payment and for ongoing recurring 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, 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 Other: _____

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 Section":

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

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

The undersigned agent certifies 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 loss of coverage under the policy. I verify that the applicant has received any required Outline of Coverage.

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		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		
Sales Representative Last Name: Katz		First Name: Jonathan

Section I. Conditions and Agreement

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 representative is entitled to receive a copy of this form.
 3. 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.
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.

An Insured Person may access their dental benefit insurance once he or she has satisfied the following waiting periods.

- **there is no waiting period for class I services; (preventive).**
- **after 6 consecutive months of coverage dental benefits will increase to include the list of class II procedures; (basic restorative).**
- **after 12 consecutive months of coverage dental benefits will increase to include the list of class III procedures. (major restorative)**

NOTICE: LIMITED BENEFIT DISCLOSURE. THE POLICY YOU APPLIED FOR DOES NOT MEET THE MINIMUM STANDARDS REQUIRED BY THE BUREAU OF INSURANCE, VIRGINIA STATE CORPORATION COMMISSION, FOR INDIVIDUAL ACCIDENT AND SICKNESS POLICIES.

Minimum standards were established by the Bureau to insure the availability of health insurance contracts providing a minimum of basic benefits needed for health care. This policy does not meet the Virginia minimum standards for the following reason(s):

LIMITED BENEFIT POLICY: THIS POLICY DOES NOT PAY FOR ANY MEDICAL SERVICES. IT PROVIDES FOR CERTAIN DENTAL SERVICES ONLY.

I have read this disclosure and realize that this policy does not meet minimum standards required by Virginia law and that it can only be sold as a LIMITED BENEFIT 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 has not received written notice of the coverage prior to the loss), the only liability Cigna 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 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 may result in the loss of coverage under the policy.

In the event coverage is revoked due to misrepresentation/intentional omissions; I will be responsible for reimbursing Cigna Health and Life Insurance Company for any amounts Cigna Health and Life Insurance Company paid for services rendered pursuant to a Cigna Health and Life Insurance Company plan. Cigna Health and Life Insurance Company would seek recovery from me of any dollars that Cigna Health and Life Insurance Company had been paid for any services rendered pursuant to a Cigna Health and Life Insurance Company plan. The dollars owed by me would be offset by the premiums I had paid. If the dollars of premium paid are less than the amount of reimbursement provided by Cigna Health and Life Insurance Company, the balance remaining would be my responsibility.

Primary Applicant Signature:	Today's Date: (MM/DD/YYYY)	Spouse/Domestic Partner 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)
Dependent Age 18 or Older Signature:	Today's Date: (MM/DD/YYYY)	Dependent Age 18 or Older Signature:	Today's Date: (MM/DD/YYYY)

Section J. Instructions:

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

<p>Cigna Health and Life Insurance Company Individual and Family Plans PO Box 3636 Tomball, TX 77362 FAX 1-877-484-5827</p>	<p>Virginia Medical Plans 1404 Northpoint Glen Court Herndon, VA 20170 Fax: 703-783-5913 or 888-514-4258</p>
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- 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 Cigna Health and Life Insurance Company at 1-866-GET-Cigna (1-866-438-2446) 8 am - 8 pm ET, Monday – Friday.

Section K. 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:

Primary Applicant Signature:	Today's Date: (MM/DD/YYYY)
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DISCRIMINATION IS AGAINST THE LAW

Medical coverage

Cigna complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Cigna does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Cigna:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
 - Qualified sign language interpreters
 - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
 - Qualified interpreters
 - Information written in other languages

If you need these services, contact customer service at the toll-free number shown on your ID card, and ask a Customer Service Associate for assistance.

If you believe that Cigna has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance by sending an email to ACAGrievance@Cigna.com or by writing to the following address:

Cigna
Nondiscrimination Complaint Coordinator
PO Box 188016
Chattanooga, TN 37422

If you need assistance filing a written grievance, please call the number on the back of your ID card or send an email to ACAGrievance@Cigna.com. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, DC 20201
1.800.368.1019, 800.537.7697 (TDD)
Complaint forms are available at
<http://www.hhs.gov/ocr/office/file/index.html>.



All Cigna products and services are provided exclusively by or through operating subsidiaries of Cigna Corporation, including Cigna Health and Life Insurance Company, Connecticut General Life Insurance Company, Cigna Behavioral Health, Inc., Cigna Health Management, Inc., and HMO or service company subsidiaries of Cigna Health Corporation and Cigna Dental Health, Inc. The Cigna name, logos, and other Cigna marks are owned by Cigna Intellectual Property, Inc. ATTENTION: If you speak languages other than English, language assistance services, free of charge are available to you. For current Cigna customers, call the number on the back of your ID card. Otherwise, call 1.800.244.6224 (TTY: Dial 711). ATENCIÓN: Si usted habla un idioma que no sea inglés, tiene a su disposición servicios gratuitos de asistencia lingüística. Si es un cliente actual de Cigna, llame al número que figura en el reverso de su tarjeta de identificación. Si no lo es, llame al 1.800.244.6224 (los usuarios de TTY deben llamar al 711).

Proficiency of Language Assistance Services

English – ATTENTION: Language assistance services, free of charge, are available to you. For current Cigna customers, call the number on the back of your ID card. Otherwise, call 1.800.244.6224 (TTY: Dial 711).

Spanish – ATENCIÓN: Hay servicios de asistencia de idiomas, sin cargo, a su disposición. Si es un cliente actual de Cigna, llame al número que figura en el reverso de su tarjeta de identificación. Si no lo es, llame al 1.800.244.6224 (los usuarios de TTY deben llamar al 711).

Chinese – 注意：我們可為您免費提供語言協助服務。對於 Cigna 的現有客戶，請致電您的 ID 卡背面的號碼。其他客戶請致電 1.800.244.6224（聽障專線：請撥 711）。

Vietnamese – XIN LỜI Ý: Quý vị được cấp dịch vụ trợ giúp về ngôn ngữ miễn phí. Dành cho khách hàng hiện tại của Cigna, vui lòng gọi số ở mặt sau thẻ Hội viên. Các trường hợp khác xin gọi số 1.800.244.6224 (TTY: Quay số 711).

Korean – 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 현재 Cigna 가입자님들께서는 ID 카드 뒷면에 있는 전화번호로 연락해주시십시오. 기타 다른 경우에는 1.800.244.6224 (TTY: 다이얼 711)번으로 전화해주시십시오.

Tagalog – PAUNAWA: Makakakuha ka ng mga serbisyo sa tulong sa wika nang libre. Para sa mga kasalukuyang customer ng Cigna, tawagan ang numero sa likuran ng iyong ID card. O kaya, tumawag sa 1.800.244.6224 (TTY: I-dial ang 711).

Russian – ВНИМАНИЕ: вам могут предоставить бесплатные услуги перевода. Если вы уже участвуете в плане Cigna, позвоните по номеру, указанному на обратной стороне вашей идентификационной карточки участника плана. Если вы не являетесь участником одного из наших планов, позвоните по номеру 1.800.244.6224 (TTY: 711).

Arabic – برجاء الانتباه خدمات الترجمة المجانية متاحة لكم. لعملاء Cigna الحاليين برجاء الاتصال بالرقم المدون علي ظهر بطاقتكم الشخصية. او اتصل ب 1.800.244.6224 (TTY: اتصل ب 711).

French Creole – ATANSYON: Gen sèvis èd nan lang ki disponib gratis pou ou. Pou kliyan Cigna yo, rele nimewo ki dèyè kat ID ou. Sinon, rele nimewo 1.800.244.6224 (TTY: Rele 711).

French – ATTENTION: Des services d'aide linguistique vous sont proposés gratuitement. Si vous êtes un client actuel de Cigna, veuillez appeler le numéro indiqué au verso de votre carte d'identité. Sinon, veuillez appeler le numéro 1.800.244.6224 (ATS : composez le numéro 711).

Portuguese – ATENÇÃO: Tem ao seu dispor serviços de assistência linguística, totalmente gratuitos. Para clientes Cigna atuais, ligue para o número que se encontra no verso do seu cartão de identificação. Caso contrário, ligue para 1.800.244.6224 (Dispositivos TTY: marque 711).

Polish – UWAGA: w celu skorzystania z dostępnej, bezpłatnej pomocy językowej, obecni klienci firmy Cigna mogą dzwonić pod numer podany na odwrocie karty identyfikacyjnej. Wszystkie inne osoby prosimy o skorzystanie z numeru 1 800 244 6224 (TTY: wybierz 711).

Japanese – 注意事項: 日本語を話される場合、無料の言語支援サービスをご利用いただけます。現在のCignaのお客様は、IDカード裏面の電話番号まで、お電話にてご連絡ください。その他の方は、1.800.244.6224 (TTY: 711)まで、お電話にてご連絡ください。

Italian – ATTENZIONE: Sono disponibili servizi di assistenza linguistica gratuiti. Per i clienti Cigna attuali, chiamare il numero sul retro della tessera di identificazione. In caso contrario, chiamare il numero 1.800.244.6224 (utenti TTY: chiamare il numero 711).

German – ACHTUNG: Die Leistungen der Sprachunterstützung stehen Ihnen kostenlos zur Verfügung. Wenn Sie gegenwärtiger Cigna-Kunde sind, rufen Sie bitte die Nummer auf der Rückseite Ihrer Krankenversicherungskarte an. Andernfalls rufen Sie 1.800.244.6224 an (TTY: Wählen Sie 711).

Persian (Farsi) – توجه: خدمات کمک زبانی، به صورت رایگان به شما ارائه می‌شود. برای مشتریان فعلی Cigna، لطفاً با شماره‌ای که در پشت کارت شناسایی شماست تماس بگیرید. در غیر اینصورت با شماره 1.800.244.6224 (شماره تلفن ویژه ناشنوايان: شماره 711 را شماره‌گیری کنید).