Clear Fields

CIGNA HealthCare of Arizona

INDIVIDUAL & FAMILY PLAN
MEDICALLY UNDERWRITTEN ENROLLMENT APPLICATION

APPLICATION FOR:	SINGLE ☐ FAMILY ☐ CHILD(REN) ONLY ☐	☐ PHOENIX AREA ☐ TUCSON AREA CIGNA MEDICAL GROUP* ☐ ARIZONA PROVIDER NETWORK* ☐
ENROLLING FOR:	EXISTING MEMBER, ADDING DEPENDENT(S) YES ☐ NO ☐	PROPOSED EFFECTIVE DATE

INFORMATION REGARDING THE APPLICANT - PLEASE PRINT

LAST NAME	FIRST NAME	MI	SOCIAL SECURITY NO.

DATE OF BIRTH	AGE	MARRIED ☐ SINGLE ☐	MALE ☐ FEMALE ☐	HEIGHT	WEIGHT	HOME PHONE NO. ( ) -

HOME ADDRESS (MUST RESIDE IN SERVICE AREA 9 MONTHS OF CALENDAR YEAR)	WORK PHONE NO. ( ) -

CITY	STATE	ZIP CODE	PRIMARY CARE PHYSICIAN NUMBER	EXISTING PATIENT? YES ☐ NO ☐

MAILING ADDRESS (IF P.O. BOX)	CITY	STATE	ZIP CODE

COMPLETE THE FOLLOWING INFORMATION FOR EACH PERSON TO BE CONSIDERED FOR ENROLLMENT. IF YOU HAVE MORE THAN TWO CHILDREN, ATTACH AN ADDITIONAL APPLICATION WITH THE SAME COMPLETE INFORMATION. WHEN ADDING A DEPENDENT TO YOUR EXISTING COVERAGE, LIST ONLY THE DEPENDENT TO BE ADDED.

SPOUSE

LAST NAME	FIRST NAME	MI	SOCIAL SECURITY NO.

DATE OF BIRTH	AGE	MALE ☐ FEMALE ☐	HEIGHT	WEIGHT	PRIMARY CARE PHYSICIAN NUMBER	EXISTING PATIENT? YES ☐ NO ☐

CHILDREN

LAST NAME	FIRST NAME	MI	SOCIAL SECURITY NO.

DATE OF BIRTH	AGE**	MALE ☐ FEMALE ☐	HEIGHT	WEIGHT	RELATIONSHIP	PRIMARY CARE PHYSICIAN NUMBER	EXISTING PATIENT? YES ☐ NO ☐

LAST NAME	FIRST NAME	MI	SOCIAL SECURITY NO.

DATE OF BIRTH	AGE**	MALE ☐ FEMALE ☐	HEIGHT	WEIGHT	RELATIONSHIP	PRIMARY CARE PHYSICIAN NUMBER	EXISTING PATIENT? YES ☐ NO ☐

*CIGNA MEDICAL GROUP IS AVAILABLE TO MEMBERS IN THE PHOENIX SERVICE AREA ONLY. ALL FAMILY MEMBERS MUST SELECT THEIR PCP FROM THE SAME PROVIDER NETWORK (CIGNA MEDICAL GROUP OR ARIZONA PROVIDER NETWORK).

**IF YOU HAVE LISTED A DEPENDENT AGE 19 OR OLDER, YOU MUST PROVIDE VERIFICATION OF FULL-TIME STATUS FROM THE SCHOOL REGISTRAR'S OFFICE.

Are you or is any person to be enrolled currently covered under any type of health benefit plan or insurance? ☐ Yes ☐ No
If yes, complete the following:

Persons Covered: _____ Health benefit plan/insurer: _____ _____ _____
EFFECTIVE DATE TERMINATION DATE

I acknowledge and agree that coverage shall become effective only after (a) this Application has been accepted upon review of the health history I have provided and any medical information reviewed by CIGNA HealthCare, and (b) a Service Agreement has been issued by CIGNA HealthCare of Arizona, Inc.

The above statements and/or those on the Evidence of Insurability form 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 into membership of CIGNA HealthCare of Arizona. **I acknowledge and agree that any misrepresentation or omission regarding the presence of pre-existing conditions, diseases, or other medical condition of any applicant will render this Service Agreement null and void from its date of issue.**

I understand that any illness or condition that may occur or be discovered between the date of my application and the effective date of coverage must be reported to CIGNA HealthCare of Arizona. In such event, I further understand that my application may again be reviewed by CIGNA HealthCare of Arizona to determine final approval.

I HAVE READ AND UNDERSTAND THE AUTHORIZATION ON THE REVERSE SIDE OF THIS FORM.

NOTE: AN EVIDENCE OF INSURABILITY FORM MUST BE COMPLETED AND SUBMITTED TO CIGNA HEALTHCARE OF ARIZONA ALONG WITH THIS ENROLLMENT APPLICATION AND A CHECK FOR THE NON-REFUNDABLE $15.00 APPLICATION FEE. **EXPENSES, IF ANY, ASSOCIATED WITH OBTAINING MEDICAL RECORDS ARE THE APPLICANT'S FINANCIAL RESPONSIBILITY.**

I AGREE ON BEHALF OF MYSELF AND AS AUTHORIZED AGENT OR REPRESENTATIVE OF MY ELIGIBLE DEPENDENTS TO THE PROVISIONS CONTAINED ON THE REVERSE OF THIS FORM, INCLUDING THE PROVISIONS REGARDING THE RELEASE OF MEDICAL INFORMATION.

Signature X _____ DATE
APPLICANT OR PARENT/GUARDIAN

Signature X _____ DATE
SPOUSE (if to be enrolled)

FOR OFFICE USE ONLY

Approved By _____ **Date** _____
Group No. _____ **Division No.** _____ **Eff. Date** _____ **Rate** _____

FOR AGENT USE ONLY

Agent or Agency Name (please print) _____ **Agent No. (Required)** _____
Address _____
Signature _____ **Phone # (** _____ **)** _____

Please Read and Sign Reverse Side

PROVISIONS

1. I understand that Primary Care Physicians may be network-affiliated and that my choice of Primary Care Physician may affect the hospitals, specialty care and other providers to which or whom I am referred.

2. I understand that during the application process and after my enrollment, CIGNA HealthCare of Arizona, Inc. and other direct or indirect subsidiaries of CIGNA Corporation (collectively "CIGNA") may need to obtain and provide Confidential Information to others. For purposes of this Paragraph and Paragraphs 3 and 4 below, "Confidential Information" means Medical Record Information, Personal Information and/or Privileged Information as defined by applicable law; dental, disability, accident or workers' compensation related information, and expressly includes the following: **CONFIDENTIAL HIV-RELATED INFORMATION (AS DEFINED IN A.R.S. SECTION 36-66, CONFIDENTIAL ALCOHOL OR DRUG ABUSE RELATED INFORMATION (AS DEFINED IN 42 CFR SECTION 2.1 ET SEQ.), CONFIDENTIAL MENTAL HEALTH DIAGNOSIS/TREATMENT INFORMATION, AND CONFIDENTIAL GENETIC TESTING INFORMATION (AS DEFINED IN A.R.S. SECTION 12-2801).**

3. I authorize any insurance institution, employer, provider, insurance support organization, health care organization, and their agents and representatives to provide Confidential Information on request by CIGNA to representatives of CIGNA who are authorized by CIGNA to receive such information, to any CIGNA participating provider, or to any other provider, person or entity performing a service for the following purposes: establishing eligibility under the Plan, Plan administration, validating services and benefits payable under the Plan, performance of peer review, utilization management, quality assurance, grievance and appeals, care management, and/or to assess the quality of or access to health care services and supplies. I further authorize CIGNA (through its agents and representatives who are authorized by CIGNA to disclose confidential information) to provide Confidential Information to the persons or entities above when it determines that such disclosure is necessary or appropriate for the purposes specified in this paragraph.

4. I am providing this authorization for myself and as agent or representative of my spouse and any dependent children. I understand that this authorization will remain in effect until I send written notice revoking it to CIGNA or for such shorter period as required by law. I understand that to the extent this authorization applies to information collected in connection with this application for coverage, the authorization is valid for a period of thirty (30) months. I further understand that to the extent this authorization applies to information collected in connection with a claim for benefits under the Plan, the authorization is valid for with respect to services received during the term of coverage under the Plan. Until revoked by me or by operation of law, this authorization remains in effect and may be relied on by CIGNA and other parties.

5. I understand that any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act and may be subject to civil and criminal penalties.

6. I authorize that payment be made under Part B of Medicare to CIGNA for medical and other services furnished by CIGNA for which it pays or has paid, if applicable.

7. I agree that in the event health services provided are the primary responsibility of Medicare, workers' compensation coverage or automobile medical payments coverage, to fully inform CIGNA and execute such documents and provide such assistance as may be necessary to enable CIGNA to recover the value of services provided or arranged.

8. I understand that I or my authorized representative is entitled to receive a copy of this authorization form.

Signature X _____ DATE
APPLICANT OR PARENT/GUARDIAN

Signature X _____ DATE
SPOUSE (if to be enrolled)

Clear Fields

PLEASE PRINT

EVIDENCE OF INSURABILITY

CIGNA HealthCare of Arizona

APPLICANT'S LAST NAME FIRST MIDDLE INITIAL

1. HAVE YOU OR ANY PERSON TO BE ENROLLED EVER HAD KNOWLEDGE OF OR BEEN DIAGNOSED, TREATED OR EVALUATED FOR ANY OF THE FOLLOWING? EACH ITEM MUST BE CHECKED YES OR NO.

YES	NO		YES	NO		YES	NO		YES	NO	
☐	☐	Abnormal Pap smear (within past 12 mos.)	☐	☐	Breast disease, Breast implants	☐	☐	Heart problem, Chest pains	☐	☐	Prostate, Male sex organ problems
☐	☐	Alcoholism, Drug abuse	☐	☐	Broken bone, Bone disease	☐	☐	Hepatitis (Please specify type)	☐	☐	Psychiatric disorders
☐	☐	Anemia, Blood disease	☐	☐	Cancer	☐	☐	Hernia (Please specify type)	☐	☐	Seizures, Stroke
☐	☐	Anxiety, Depression	☐	☐	Cataracts, Glaucoma	☐	☐	High blood pressure	☐	☐	Sexually transmitted disease
☐	☐	Arthritis, Gout, Bursitis	☐	☐	Concussion, Head injury	☐	☐	HIV/AIDS	☐	☐	Skin disease, Skin problems
☐	☐	Artificial limb	☐	☐	Convulsions, Epilepsy	☐	☐	Infertility treatment	☐	☐	Stomach problems, Colitis
☐	☐	Asthma, Bronchitis	☐	☐	Crossed eyes, Other eye disease	☐	☐	Intestinal problem	☐	☐	Thyroid, Glandular disease
☐	☐	Attention Deficit Hyperactivity Disorder (ADHD)	☐	☐	Diabetes, Hypoglycemia	☐	☐	Kidney stone, Kidney problem	☐	☐	Tumor, Cyst
☐	☐	Back or spine problem	☐	☐	Ear problem, Hearing loss	☐	☐	Liver disease, Cirrhosis	☐	☐	Ulcer (Please specify location)
☐	☐	Birth defects, Deformity	☐	☐	Emphysema, Lung problem	☐	☐	Menstrual problems, Female disorder	☐	☐	Uterus, Ovarian problems
☐	☐	Bladder problems	☐	☐	Gallbladder disease or problem	☐	☐	Paralysis, Nervous system problem	☐	☐	Weight problem
☐	☐	Brain disease	☐	☐	Headaches, Migraines	☐	☐	Prosthesis, Implants			

2. ☐ Yes ☐ No Have you or any person to be enrolled ever had an operation? **Give complete details below.**

3. ☐ Yes ☐ No Have you or any person to be enrolled been advised to have any operation not yet performed? **Give complete details below.**

4. ☐ Yes ☐ No Has any person to be enrolled visited a physician, clinic or hospital **for any reason whatsoever (including physical examination by a Primary Care Physician)** within the last five years? **Give details, date and reason seen, complete name and address of doctor below.**

5. ☐ Yes ☐ No Is any person to be enrolled currently taking medication? **If yes, list medications** _____

6. ☐ Yes ☐ No Is any male listed on this application currently expecting a child with anyone, either natural or by adoption, even if the mother is not listed on this application?

IF THE ANSWER IS YES TO ANY PART OF QUESTION 1-5 ABOVE, COMPLETE DETAILS MUST BE GIVEN BELOW: Use additional pages if necessary.

QUES. NO.	NAME OF PERSON	DATE TREATMENT BEGAN	REASON FOR VISIT, TYPE OF SURGERY, PROBLEM, NAME OF MEDICATION	DATE TREATMENT ENDED	DOCTOR OR HOSPITAL NAME YOU MUST GIVE THE COMPLETE NAME, STREET ADDRESS, CITY & ZIP CODE
					NAME PHONE STREET ADDRESS CITY STATE ZIP
					NAME PHONE STREET ADDRESS CITY STATE ZIP
					NAME PHONE STREET ADDRESS CITY STATE ZIP
					NAME PHONE STREET ADDRESS CITY STATE ZIP
					NAME PHONE STREET ADDRESS CITY STATE ZIP

7. Please provide the COMPLETE name and address of **your current physician.**

NAME ADDRESS CITY STATE ZIP

8. Have you or any person to be enrolled ever used tobacco products? ☐ Yes ☐ No If Yes, please COMPLETE the following:

A. Name of person(s) _____ B. ☐ Cigarettes ☐ Cigars ☐ Pipe ☐ Chewing tobacco: _____

C. Identify quantity per day _____ D. How many years? _____ E. Has the person(s) quit? ☐ Yes ☐ No If Yes, when? _____

9. Have you or any person to be enrolled ever been refused health insurance? ☐ Yes ☐ No If Yes, person: _____

Date refused: _____ Reason refused: _____

10. Are you or is any person to be enrolled currently undergoing treatment or is any treatment or visit to a hospital or a physician anticipated? ☐ Yes ☐ No

If Yes, person: _____ Treatment/Problem: _____

FEMALES MUST COMPLETE THE FOLLOWING:

11. Is any female to be enrolled now pregnant? ☐ **Yes** ☐ **No** **If Yes, expected date of delivery:** _____

12. The name and date of the last menstrual period of each female must be listed below.

Name: _____ **Last Menstrual Period:** _____ **Last Pap:** _____

Name: _____ **Last Menstrual Period:** _____ **Last Pap:** _____

Name: _____ **Last Menstrual Period:** _____ **Last Pap:** _____

Signature X _____ **DATE** _____ **Signature X** _____ **DATE** _____

APPLICANT or PARENT/GUARDIAN SPOUSE (if to be enrolled)

(INCLUDE ADDITIONAL PAGES AS NECESSARY)