

Request for Small Group Insurance
2-50 Lives only
Arizona



We want to thank you for choosing CIGNA for your medical insurance and look forward to serving you and your Employees. Please return this completed form with your deposit check and employee applications for your case to Be implemented on the effective date requested. The acceptance of this letter does not guarantee issuance of a Policy. Final rates and policy issuance are based on actual enrollment and are subject to Home Office Underwriting Approval. *As a reminder, we require the employer to contribute at least 50% of the total covered employee's premium.*

Name of Employer _____		Total Eligible at Site(s) _____	
Billing Contact Name _____			
Address _____			
City _____	State _____	Zip _____	
Nature of Business/SIC Code _____		Requested Effective Date _____	
Phone Number _____		Fax Number _____	
New Hire Waiting Period – First of month following <input type="radio"/> 0 Days <input type="radio"/> 30 Days <input type="radio"/> 60 Days <input type="radio"/> 90 Days			
Deposit Check Amount \$ _____		(Equal to first month's premium) <i>Make check payable to CIGNA</i>	
Current Health Insurance Carrier _____		Plan Type _____	
Policy # _____	Effective Date _____	<i>Please attach copy of previous month's bill</i>	
Tax I.D.# _____		ERISA# _____	
Plan Selection (circle one)			
HMO: \$15/\$250 F	\$20/\$500 G	\$25/\$1000/90% H	\$30/\$1000/80% I
POS: \$15/\$250 A	\$20/\$500 B	\$25/\$1000/90% C	\$30/\$1000/80% K
OAP: \$20/\$500 L	\$25/\$5000 M	\$25/\$1000 N	\$25/\$1500 O
Employer will contribute _____		% of each covered employee's premium (Minimum is 50%)	
Employer will contribute _____		% of dependent premium (Contribution not required)	

ACKNOWLEDGEMENT OF ADMINISTRATIVE GUIDELINES

- Premiums are payable on or before the last day of the month for services rendered in the following month. If payment is not received and posted to your account by the fifteenth of that coverage month, coverage will be terminated, no reinstatements – no exceptions.
- The new hire-waiting period may only be changed upon annual renewals.
- A minimum participation of 75% of eligible employees must enroll. If the employer is paying 100% of all premium, all eligible employees must enroll. Arizona law authorizes eligibility restrictions based on seasonal or part-time employment only if imposed by the employer and not CIGNA HealthCare.
- Waiver of coverage and proof of insurance are required for any employee declining coverage,
- Members may call our Member Services Representatives at 1-800-832-3211 with all questions concerning benefits and ID cards. Benefit Administrator may call Employer Account Service Center at 1-800-592-9219.
- Please mail initial enrollment applications to this address: CIGNA Healthcare, Attention: Small Group Sales, 11001 N. Black Canyon Highway Ste. 300 , Phoenix, AZ 85029 by the 15th of the month in order to have coverage effective the first of the following month. All future Enrollment/Change Forms are to be sent to the address on the top right of the Enrollment/Change Form.

I understand and will adhere to the above Administrative Guidelines.

Employer Signature _____ Date _____

Broker Signature _____ Date _____