Insured and/or Administered by
Connecticut General Life Insurance Company
CIGNA HealthCare

CIGNA Dental Enrollment / Change Form

Please print and thank you for providing this information

A	☐ New Enrollment ☐ Open Enrollment ☐ Change in Status	Hire Date Effective Date	Employer Name **University of Massachusetts Medical School**
	CIGNA Account No **3335254**	Type of Change ☐ Add Dependent(s) *(List Names in Section B)* ☐ Cancel Coverage ☐ Waive Coverage ☐ Remove Dependents (*List Names in Section B*)	

B	Employee Name *(last)* *(first)* *(M.I.)*				Social Security No.
	Employee Date of Birth	Home Phone	Work Phone	Work E-Mail Address	UMass Employee ID #
	Address *(Street)* *(City)* *(State)* *(Zip Code)*				

Last Name	First Name	Date of Birth	Gender	
Spouse (specify last name if different from employee)		| |	☐ M ☐ F	
Dependent (specify last name if different from employee)		| |	☐ M ☐ F	
Dependent (specify last name if different from employee)		| |	☐ M ☐ F	
Dependent (specify last name if different from employee)		| |	☐ M ☐ F	
Dependent (specify last name if different from employee)		| |	☐ M ☐ F	
Dependent (specify last name if different from employee)		| |	☐ M ☐ F	
Dependent (specify last name if different from employee)		| |	☐ M ☐ F	
Dependent (specify last name if different from employee)		| |	☐ M ☐ F	

C	Coverage Level ☐ INDIVIDUAL ☐ FAMILY	D	Dental Options ☐ BASIC Dental PPO Plan (Code - DPPOB) ☐ FACULTY/EXECUTIVE Dental PPO Plan (Code - DPPOF) ☐ PLUS Dental PPO Plan (Code - DPPOP)

	Signature – The information provided above is true and correct to the best of my knowledge.	
E	Employee's Signature/ Date	Employer's Signature / Date