

**Global Health Advantage 2 to 9
Enrollment / Change Form**

CIGNA International

Mailing Address: P.O. Box 15050
Wilmington, DE 19850



Section A - About You			Hire Date:
Account Number:	Employer Name:		Coverage Effective Date:
Last Name:	First Name:		Middle Name:
Gender: M F	Marital Status:	Birth Date:	
Country of assignment:		Country of citizenship:	

Current International Assignment Information (if necessary, please use the reverse side for additional addresses)

Address:	Street:	Home phone number:	
	City:		Work phone number:
	Postal/ZIP code:	State/Province:	Facsimile number:
	Country:	E-mail address*:	
*Do you agree to accept the Notice of Privacy Practices from our Privacy Office electronically? Yes No			

Section B - Your Benefit Elections

Medical	Employee Basic Life	Annual Base Salary \$
Dental	AD&D	
Long Term Disability		

Section C - Your Dependent Benefit Elections

Coverage Type	Please List the Name of Dependent	Relationship	Birth Date	Gender	Full-time student? **	Country of Residence
Medical Dental		Spouse		M F	Not Applicable	
Medical Dental				M F	Yes No	
Medical Dental				M F	Yes No	
Medical Dental				M F	Yes No	
Medical Dental				M F	Yes No	

**Please submit proof of full-time student status if dependent child is age 19 or over. If totally disabled prior to age 19, attach proof of disability for eligibility review.

Section D - Changes

If You Need to:	Then Provide This Information:
ADD: _____ Spouse	Date of Marriage
_____ Add Dependent Child	Date of Birth / Adoption:
DELETE: _____ Spouse	Termination Date:
_____ Dependent(s)	Termination Date:
_____ All Coverages	Former Name:
CHANGE: _____ Your Name	SHOW NEW ADDRESS IN SECTION A
_____ Your Address	Effective Date:
_____ Your Work Location	
ADD COVERAGE: Non-Medical Coverage	Dental Coverage
OTHER:	

Section E – Beneficiary Information (for Life & AD&D Insurance)			
Name(s) of Beneficiaries	Relationship	Address	Percentage of Insurance
			%
			%
			%

This designation revokes any and all previous designations. The right to further change the beneficiary is reserved unto the Insured. Unless otherwise provided, where two or more beneficiaries are named under Life Insurance coverage, if any, the proceeds shall be paid in equal shares to the named beneficiaries, if surviving the insured. If no beneficiary survives, payment shall be made in accordance with the terms of the policy.

Employee signature: _____ Date: _____

Type of Change – please check off the appropriate change and complete the following sections:

- *New Enrollment*: complete sections A, B, C, and E (if applicable)
- *Add/Remove Dependent*: complete sections A, C and D
- *Add/End/Change Coverage(s)*: complete sections A, B and D
- *End all Coverage(s)*: complete sections A and D
- *Address Change*: complete sections A and D

Country of Residence Please list the country where each dependent lives. This information helps CIGNA International provide better customer service to you and your dependents.

Additional Addresses Please list any other addresses, who is at that address, and how CIGNA International should use that address (for example: claim payments)

Provisions

I authorize deductions from my earnings of the required contributions, if any, toward the cost of the insurance. This authorization applies only if employee contributions are required.

AUTHORIZATION TO DISCLOSE CONFIDENTIAL INFORMATION

I hereby authorize any person or entity having my Confidential Information to provide it to CIGNA International * and I authorize CIGNA International to provide my Confidential Information to any person or entity for the purpose of payment of my claims and health care operations. I am making this authorization for myself and as the 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 International, or for such shorter period as may be required by law. Until revoked, CIGNA International, and other parties disclosing my Confidential Information to CIGNA International for the purposes set forth above, may rely upon this authorization. I understand that I may ask to receive a copy of this authorization.

* “CIGNA International” refers to the various operating subsidiaries of CIGNA Corporation. Products and services are provided by these subsidiaries and not by CIGNA Corporation. CIGNA Corporation is a holding company and is not an insurance or operating company.

FRAUD NOTICE: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

Send Form to:

For Mail Deliveries:
 CIGNA International Expatriate
 Benefits
 P.O. Box 15050
 Wilmington, DE 19850

Direct Fax: 302.797.3180

For Courier Deliveries
 CIGNA International Expatriate
 Benefits
 590 Naamans Road
 Claymont, DE 19703