Enrollment or Change Form
CIGNA HMO and PPO
Dental Plans 3217088

☐ New Member ☐ Reinstatement ☐ Coverage Change ☐ Name Change
Effective Date_____**(AFSPA USE ONLY)**

Name_____
Last First M.I Gender ☐Male ☐Female ☐I prefer not to say

Address_____ Date of Birth _____

_____ Social Security #_____

Agency Name_____ Home Phone _____

E-mail Address _____ Work Phone _____

Choose One:

CIGNA Dental HMO ☐
Dental Office Selection **Required** for HMO
1.) _____
2.) _____

CIGNA Dental PPO ☐
Dental Office Selection **Not Required** for PPO

Please visit www.CIGNA.com to locate a participating dentist or call:
1-800-367-1037 for CIGNA Dental Care HMO
1-888-336-8258 for a CIGNA Dental Care PPO

Are you or any members of your family covered under any other group or dental plan? Yes ☐ No ☐
If "yes", give name of person covered and identify the insurance carrier name, address and ID number:

_____

Dependent Information

Spouse's Name_____Date of Birth _____

Spouse's SS# _____ Date of Marriage _____
(*For change of coverage only*)

Spouse Gender □ Male □ Female □ I prefer not to say

DHMO Office Selection 1.)_____ 2.) _____

**** Children covered until age 26****

Name	Social Security Number	Date of Birth	Gender (M/F/Other)	DHMO Dental Office Selection

Please turn over

☐ **I hereby request enrollment in the CIGNA HMO/PPO dental plan. AFSPA encourages enrollment for a minimum of one year.**

Coverage Type	**Single** ☐	**Two-Party** ☐	**Family** ☐
Bill Me	**Quarterly** ☐	**Annually** ☐	

By my signature, I hereby request Membership in the Protective Association's Dental Program through CIGNA Dental.

I authorize payment of dental benefits to the provider of dental care.

I authorize any participating dental office to release dental records and billing information concerning me or my dependents to CIGNA Dental Health and Connecticut General Life Insurance Company for purposes of plan administration or for the purpose of validating and determining benefits payable. I further authorize CIGNA Dental Health and Connecticut General Life Insurance Company to release any records or information concerning me or my dependents to its designee, for purposes of plan administration and customer service.

Signature_____ **Date**_____

Please forward the completed form to AFSPA using the information below:

Mail:	American Foreign Service **Protective Association** 1620 L Street NW, Suite 800 Washington, DC 20036
Fax:	(202) 775-9082
Online:	**https://www.afspa.org/secureform.cfm?FormName=Dental-Plan-Question**