Enrollment or Change Form
CIGNA International
Dental Plan 00040A999

☐ New Member ☐ Reinstatement ☐ Coverage Change ☐ Name Change

Effective Date _____ (AFSPA USE ONLY)

Name _____
Last First M.I.

Address _____ Date of Birth _____

_____ Gender ☐Male ☐Female ☐I prefer not to say

Social Security #_____

Country _____ Agency Name _____

Home Phone _____ Work Phone _____

E-mail Address _____

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# ___ Gender: ☐Male ☐Female ☐I prefer not to say

Date of Marriage (*For change of coverage only*) _____

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

Name	Social Security Number	Date of Birth	Gender (M/F/Other)

Coverage Type Single ☐ Two-Party ☐ Family ☐

Bill Me Quarterly ☐ Annually ☐

By my signature, I hereby request enrollment in the Protective Association's CIGNA International dental plan. AFSPA encourages enrollment for a minimum of one year.

Signature_____ Date_____

Mail: American Foreign Service **Protective Association**
1620 L Street NW, Suite 800
Washington, DC 20036
Fax: (202) 775-9082
Online: **https://www.afspa.org/secure-form-dental-plan-question/**