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 ☐

1620 L Street NW, Suite 800, Washington, DC 20036-2902 Phone:(202) 833-4910
Web site: www.AFSPA.org/dental E-mail: dental@AFSPA.org Fax: (202) 775-9082

☐ **I hereby request enrollment in the CIGNA International dental plan. AFSPA encourages enrollment for a minimum of one year. I understand that cancellation requests must be submitted in writing to AFSPA directly and your policy will be terminated on the 1st day of the month following the date of receipt of cancellation request.**

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

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/**