Town of Marshfield

CIGNA Plan QD-V9

CIGNA DENTAL CARE ACCESS PLUS NETWORK

Social Security # _____ Circle one: Retiree or Active

Last Name _____ First name _____ Initial _____

Street: _____ City: _____

State: _____Zip Code : _____ Phone _____

Date of Birth: ___/____/_____ Sex: M/F Marital Status: _____Date of Hire _____

Email: _____

I apply for coverage on:

Employee Only _____ Employee plus 1 _____ Family _____

List all eligible dependents to be covered:

	Last name if Different	First Name	Initial	Sex: M/F	Date of birth	Provider* Cigna Dental Care Access Plus
Self						
Spouse						
Child						
Child						
Child						
Child						

*USE CIGNA DENTAL CARE ACCESS PLUS NETWORK call 800CIGNA24 for help or questions

Please list additional dependents on a separate enrollment card.

Patient Privacy Statement

In accordance with recent Federal and State Laws regarding privacy or patient's records and information, please be advised that we will not disclose your personal health information (PHI) to anyone without your authorization or as otherwise permitted by law.

I agree to stay on the dental program for a minimum of one year (the exception being termination of employment)

EMPLOYEE SIGNATURE: _____ Date: _____

REV/5/6/2020