Georgia 2025 Employee Enrollment Application / Change Request

Instructions: With the exception of Section A, You (the employee) must complete this application. You are solely responsible for its accuracy and completeness. To avoid the possibility of delay, answer all questions and be sure to sign and date your application. Please complete this form in blue or black ink and submit to your employer when complete.

Section A: Information provided by your employer (to be completed by the employer)

Employer name	Employer group ID (ex: BIZ12345678, if unavailable, leave blank)	
Employee's work address		
City	State	ZIP code
Employee's status (check all options that apply):	☐ Active ☐ Union ☐ Non-union ☐ Hourly ☐ Salary ☐ Other (please explain):	
Hours worked per week?	Date of hire (mm/dd/yyyy)	

Section B: Application type

Application type

☐ New application ☐ Change benefits plan ☐ Information update (name, address, etc.)
☐ Add/remove a dependent ☐ Termination

Application reason

☐ Open enrollment ☐ New hire ☐ Rehire
☐ **COBRA** ☐ **Georgia State Continuation** ☐ **Qualifying Life Event**
☐ Other (please explain):

If you selected **COBRA** or **Georgia State Continuation** as the application reason above, please select one of the following qualifying life events:

☐ Left employment (voluntarily or involuntarily)
☐ Expiration of COBRA coverage
☐ Death
☐ Divorce or legal separation
☐ Loss of dependent child status
☐ Medicare entitlement
☐ Reduction in hours

Continuation qualifying event date (mm/dd/yyyy):

If you selected **Qualifying Life Event** as the application reason above, please select one of the following applicable qualifying life events*:

☐ Loss of coverage
☐ Marriage
☐ Birth
☐ Adoption/Placement for Adoption
☐ Court-ordered dependent addition
☐ Moved to service area
☐ Other: _____

Qualifying event date (mm/dd/yyyy):

*Appropriate documentation must be submitted along with this form to be eligible for coverage.

Section C: Member information

Instructions: The below information must be completed for the subscriber and any additional family members to be covered. An eligible dependent may be your spouse, domestic partner (if this option is chosen by your employer), your children, your spouse's children or your domestic partner's children (if applicable).

Coverage of a child dependent will continue to the end of the calendar month in which the child turns age 26 unless he or she qualifies as a disabled person (if you have a disabled dependent, please call us at (877) 991-2617 to request a disabled dependent form). Please attach additonal copies of this page as needed to account for more than two children.

	Employee	Spouse/Domestic Partner	Child	Child 2
Full name				
Social security number	- - ☐ Not available	- - ☐ Not available	- - ☐ Not available	- - ☐ Not available
Check all that apply:		☐ Domestic partner ☐ Employee of this business	☐ Disabled ☐ Employee of this business	☐ Disabled ☐ Employee of this business
Sex	☐ Male ☐ Female	☐ Male ☐ Female	☐ Male ☐ Female	☐ Male ☐ Female
Date of birth (mm/dd/yyyy)				
For the section below, if all members share the same details - only fill out the first column. However, if there are differences, please fill out the other respective columns. **Please Note: P.O. boxes are not valid addresses.**				
Address line 1				
Address line 2 (optional)				
City				
State				
ZIP code				
County				
Phone (xxx) xxx - xxxx				
Email				
On the day your coverage begins, if you or any of your family members will be eligible or covered by Medicare or other coverage fill out the section below.				
Eligible for Medicare	☐ Yes ☐ No If yes, why? ☐ Age ☐ Disability ☐ ESRD Onset date:	☐ Yes ☐ No If yes, why? ☐ Age ☐ Disability ☐ ESRD Onset date:	☐ Yes ☐ No If yes, why? ☐ Age ☐ Disability ☐ ESRD Onset date:	☐ Yes ☐ No If yes, why? ☐ Age ☐ Disability ☐ ESRD Onset date:

Medicare coverage (check appropriate box and list effective date and Medicare ID number)	☐ Part A: / / ☐ Part B: / / ☐ Part C: / / ☐ Part D: / / ID number:	☐ Part A: / / ☐ Part B: / / ☐ Part C: / / ☐ Part D: / / ID number:	☐ Part A: / / ☐ Part B: / / ☐ Part C: / / ☐ Part D: / / ID number:	☐ Part A: / / ☐ Part B: / / ☐ Part C: / / ☐ Part D: / / ID number:
Other health coverage (check appropriate box and list coverage dates, carrier name and Policy number)	☐ Individual ☐ Group Start date: / / End date: / / Carrier name: Policy number:	☐ Individual ☐ Group Start date: / / End date: / / Carrier name: Policy number:	☐ Individual ☐ Group Start date: / / End date: / / Carrier name: Policy number:	☐ Individual ☐ Group Start date: / / End date: / / Carrier name: Policy number:

Section D: Choose your plan

Not all plans listed may be available - check with your employer to find out which plans are offered. All plans below include pediatric dental coverage.

- ☐ Cigna Healthcare Small Group LocalPlus® Bronze $6500 HSA
- ☐ Cigna Healthcare Small Group LocalPlus® Silver $3500
- ☐ Cigna Healthcare Small Group LocalPlus® Silver $4250
- ☐ Cigna Healthcare Small Group LocalPlus® Silver $5000
- ☐ Cigna Healthcare Small Group LocalPlus® Silver $6550
- ☐ Cigna Healthcare Small Group LocalPlus® Gold $0
- ☐ Cigna Healthcare Small Group LocalPlus® Gold $1250
- ☐ Cigna Healthcare Small Group LocalPlus® Gold $2500
- ☐ Cigna Healthcare Small Group LocalPlus® Gold $3500
- ☐ Cigna Healthcare Small Group LocalPlus® Platinum $900

- ☐ Cigna Healthcare Small Group Open Access Plus Bronze $6500 HSA
- ☐ Cigna Healthcare Small Group Open Access Plus Silver $3500
- ☐ Cigna Healthcare Small Group Open Access Plus Silver $4250
- ☐ Cigna Healthcare Small Group Open Access Plus Silver $5000
- ☐ Cigna Healthcare Small Group Open Access Plus Silver $6550
- ☐ Cigna Healthcare Small Group Open Access Plus Gold $0
- ☐ Cigna Healthcare Small Group Open Access Plus Gold $1250
- ☐ Cigna Healthcare Small Group Open Access Plus Gold $2500
- ☐ Cigna Healthcare Small Group Open Access Plus Gold $3500
- ☐ Cigna Healthcare Small Group Open Access Plus Platinum $900

Section E: Terms, conditions, and authorizations

Please read this section carefully before signing the application

Eligible Employee means:
An active employee of the Employer who works the number of hours per week to be eligible for benefits as defined by the Employer, who meets the definition of "Eligible Employee" under Georgia State and Federal laws, and approved by Cigna Health and Life Insurance Co ("Cigna Healthcare Small Group") as of the effective date. Employment must be verifiable from state or federal wage tax reports;

An Eligible Employee, as defined above, who enters into employment after the coverage effective date and who completes the group imposed waiting period for eligibility (if any) and applies for coverage within 30 days;

Any other class of persons identified by the Employer, provided that written approval of their eligibility is obtained from the Company(ies); or

An Eligible Employee, who is eligible for continued coverage under Georgia State or Federal laws.

Eligible Dependent means:
Your spouse, or child age 26 or younger, including a newborn, natural child, or a child placed with You for adoption, a stepchild or any other child for whom You have legal guardianship or court ordered custody. The age limit for coverage of a child is age 26. Coverage for children will end on the last day of the month in which the children reach age 26.

An unmarried child (at any age during initial or continued enrollment), who cannot support himself or herself because of intellectual disability, mental illness, or physical incapacity that began prior to the child reaching the age limit for coverage. Coverage may be obtained for the child who is beyond the age limit at the initial enrollment if You provide proof of handicap and dependence at the time of enrollment. Dependents eligible for continued coverage under Georgia State or Federal laws.

In signing this, I represent that:

I am an Eligible Employee (as defined above), and I am requesting coverage for myself and all Eligible Dependents (as defined above) listed and authorize my Employer to deduct any required contributions for this insurance from my earnings.

I understand all benefits are subject to conditions stated in the policy documents.

I have read or have had read to me the completed application, and I realize any false statement or misrepresentation in the application may result in loss of coverage.

Printed Name	
Applicant signature Sign here **X**	Date (mm/dd/yyyy)