



# MEMBERSHIP APPLICATION

**CIGNA HealthCare of South Carolina**

### Check Reason for Application

- New Subscriber
- Conversion to Non-Group
- COBRA
- Change Name / Address
- Change a PCP/OB-GYN  
Reason \_\_\_\_\_
- Add a Family Member
- Terminate a Family Member
- Terminate Coverage  
Reason \_\_\_\_\_
- Decline Coverage  
Reason \_\_\_\_\_
- Other \_\_\_\_\_

For CHC Use Only	Group Leader Only
Group Number	Group Leader Initials
Subscriber Number	Requested Effective Date

## I. Please Tell Us About Yourself

Employee Full Name \_\_\_\_\_ Social Security Number \_\_\_\_\_  
 Mailing Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Company Name \_\_\_\_\_ Date Employed \_\_\_/\_\_\_/\_\_\_ Home Phone # (\_\_\_\_) \_\_\_\_\_  
 Marital Status:  Single  Married  Separated  Widowed  Divorced Work Phone # (\_\_\_\_) \_\_\_\_\_

## II. Please Give Us Information On Each Person To Be Covered By CIGNA HealthCare

IMPORTANT: You and each member of your family must select a Primary Care Physician from the CIGNA HealthCare Participating Physicians List. Dependent children must be under 19 unless a full time student. For each full time student, you must have the school send a letter to the CIGNA HealthCare Enrollment Department within 30 days of enrollment, verifying student status and expected date of graduation.

	Last Name	First	Middle	Sex M/F	Relation to Employee	Birthday Mo/Day/Yr	If independent child Is over 19, check		CIGNA HealthCare Primary Care Physician	Check if <input type="checkbox"/> Current Patient
							Full Time Student	Disabled		
01 EMPLOYEE									PCP	
02 SPOUSE									OB/GYN	
Social Security #									PCP	
03 DEPENDENT							<input type="checkbox"/>	<input type="checkbox"/>	OB/GYN	
Social Security #									PCP	
04 DEPENDENT							<input type="checkbox"/>	<input type="checkbox"/>	OB/GYN	
Social Security #									PCP	
05 DEPENDENT							<input type="checkbox"/>	<input type="checkbox"/>	OB/GYN	
Social Security #									PCP	
06 DEPENDENT							<input type="checkbox"/>	<input type="checkbox"/>	OB/GYN	
Social Security #									PCP	

## III. Please Answer The Questions Below

Will you or any member of your family be covered Through another health insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No	Have you or any member of your family ever been enrolled in CIGNA HealthCare before? <input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, Name of Insurance Co. _____ Effective Date: _____ Policy Number: _____	To join CIGNA HealthCare, are you transferring your coverage from any other carrier? <input type="checkbox"/> Yes <input type="checkbox"/> No
Type of coverage: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependents <input type="checkbox"/> Medical <input type="checkbox"/> Dental	Spouse's Date of Birth: ___/___/___ Is your spouse employed? <input type="checkbox"/> Yes <input type="checkbox"/> No
Names of covered individuals by other insurance:	If yes, place of employment: _____ Telephone: _____

## IV. Please Sign and Date This Application and Return to Your Personnel Department

In making application for CIGNA HealthCare of South Carolina, Inc. membership, I agree to the following for myself and all eligible family dependents: Any hospital or physician may furnish CIGNA HealthCare such medical information as may be required. CIGNA HealthCare may conduct a utilization review program of health services and coordinate benefits with other health or insurance programs. Benefits for which I (we) will be eligible are those described in the Certificate of Coverage. If the Agreements unsatisfactory for any reason, I may return it within ten (10) days of its receipt for a refund of any payments I have made if I (we) have not utilized any services. Any dispute or claim will be resolved according to the Grievance Procedures Section of the Certificate of Coverage. I authorize my employer to deduct from my pay the amount of money required for the coverage I select. All information furnished by me is true and complete to the best of my knowledge.

Employee Signature X \_\_\_\_\_ Date \_\_\_\_\_

CIGNA HealthCare Use Only

Entered By	Date	ID Cards Sent (date)
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