Cigna

Global Health Benefits

Global Health Advantage 10+ Enrollment/Change Form

Mailing Address: P.O. Box 15050
Wilmington, DE 19850

Section A. – About You

Account Number:	Coverage Effective Date:	Hire Date:	Birth Date:	Gender: ☐ M ☐ F	Marital Status:
Employer Name:		Last Name:	First Name:		Middle Name:
MIT ID	Medicare No.	Country of assignment:		Country of citizenship:	

Current International Assignment Information

Address	Street:		Home phone number:	Work phone number:
	City:	State:	E-mail address:	Facsimile number:
	ZIP code:	Country:	Do you agree to accept the Notice of Privacy Practices from Privacy Office electronically? ☐ Yes ☐ No	

If your lawful spouse resides separately from you and in the United States, please enter that United States address below.

Address	Street:		
	City:	State:	ZIP code:

Section B. – About Your Benefit Elections

☐ Medical
☐ Dental
☐ Vision

Section C. – About Your Dependents

If your Employer's plan provides coverage for a Domestic Partner, please indicate under the Relationship box below.

Coverage Type	Name of Dependent	Relationship	Birth Date	Social Security No.	Medicare No.	Gender	Other Medical Coverage	Other Dental Coverage	Country of Residence
☐ Medical ☐ Dental ☐ Vision						☐ M ☐ F	☐ Yes ☐ No	☐ Yes ☐ No	
☐ Medical ☐ Dental ☐ Vision						☐ M ☐ F	☐ Yes ☐ No	☐ Yes ☐ No	
☐ Medical ☐ Dental ☐ Vision						☐ M ☐ F	☐ Yes ☐ No	☐ Yes ☐ No	
☐ Medical ☐ Dental ☐ Vision						☐ M ☐ F	☐ Yes ☐ No	☐ Yes ☐ No	
☐ Medical ☐ Dental ☐ Vision						☐ M ☐ F	☐ Yes ☐ No	☐ Yes ☐ No	

*Dependents – Dependents are covered for medical, dental and vision (if applicable) to age 26. Proof of student status may be required for Dependent Life. If totally disabled prior to the dependent eligibility end date, attach proof of disability for eligibility review.

Section D. – Other Healthcare Coverage

If you or your dependents have other health insurance under a group plan, HMO or Medicare please provide the following:

Medical Carrier Name:	Insured Name:	Birth Date:	Effective Date:	Medicare: ☐ Part A ☐ Part B	Medicaid:
Dental Carrier Name:	Insured Name:	Birth Date:	Effective Date:	Medicare: ☐ Part A ☐ Part B	Medicaid:

Section E. – Changes

☐ Add Spouse	Date of Marriage:	☐ Add Dependent Child	Date of Birth / Adoption:		
☐ Cancel Spouse	Termination Date:	☐ Cancel Dependent(s)	Termination Date:	☐ Cancel All Coverages	Termination Date:
☐ Name Change	Former Name:	☐ Your Address (SHOW NEW ADDRESS IN SECTION A)		☐ Your Work Location	Effective Date:
ADD COVERAGE:	☐ Non-Medical Coverage	☐ Dental Coverage			
OTHER:					

Employee signature: _____ Date: _____

Provisions

I authorize deductions from my earnings of the required contributions, if any, toward the cost of the insurance.
This authorization applies only if employee contributions are required.

I agree, for myself and my dependents, that, in the event any health services provided are the primary responsibility of any other party by way of other group health coverage, or by the act or omission of another person to fully inform the insurer, I will execute such assignments, liens or other documents which may be necessary to enable the insurer to recover the value of the services provided. I further agree that in the event I or any of my dependents collect benefits or damages from any other party who has primary responsibility for services provided by the insurer, I will immediately reimburse the insurer to the extent of services provided, to the extent permitted by applicable law.

FRAUD NOTICE: Any person who, knowingly and with intent to defraud any insurance company or other person: (1) files an application for insurance or statement of claim containing any materially false information; or (2) conceals for the purpose of misleading, information concerning any material fact thereto, commits a fraudulent insurance act.

Send Forms To: Once this form is completed in its entirety, please return to your employer's Human Resources Department