Enrollment or Change Form
CIGNA HMO and PPO
Dental Plans 3217088

☐ New Member ☐ Reinstatement ☐ Coverage Change ☐ Name Change
Effective Date_____**(AFSPA USE ONLY)**

Name_____
Last First M.I.

Address_____ Date of Birth _____

_____ Social Security #_____

Agency Name_____ Home Phone _____

E-mail Address _____ Work Phone _____

Choose One:

CIGNA Dental HMO ☐
Dental Office Selection **Required** for HMO
1.) _____
2.) _____

CIGNA Dental PPO ☐
Dental Office Selection **Not Required** for PPO

Please visit www.CIGNA.com to locate a participating dentist or call:
1-800-367-1037 for CIGNA Dental Care HMO
1-888-336-8258 for a CIGNA Dental Care PPO

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# _____ Date of Marriage _____
(*For change of coverage only*)

DHMO Office Selection 1.)_____ 2.) _____

**** Children covered until age 26****

Name	Social Security Number	Date of Birth	Gender (M/F)	DHMO Dental Office Selection

Please turn over

1620 L Street NW, Suite 800, Washington, DC 20036-2902 (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 HMO/PPO 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 your cancellation request. You will not be eligible to re-enroll for 1-year from the effective date of termination.**

☐ **I acknowledge that I am enrolling in a private plan and understand that AFSPA does not deduct premiums from my bi-weekly payroll or monthly annuity payments. Payments must be submitted to AFSPA via check or direct debit. Credit card payment options are also available by logging into my member portal.**

Coverage Type **Single** ☐ **Two-Party** ☐ **Family** ☐

Bill Me **Quarterly** ☐ **Annually** ☐

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

I authorize payment of dental benefits to the provider of dental care.

I authorize any participating dental office to release dental records and billing information concerning me or my dependents to CIGNA Dental Health and Connecticut General Life Insurance Company for purposes of plan administration or for the purpose of validating and determining benefits payable. I further authorize CIGNA Dental Health and Connecticut General Life Insurance Company to release any records or information concerning me or my dependents to its designee, for purposes of plan administration and customer service.

Signature_____ **Date**_____

Please forward the completed form to AFSPA using the information below:

Mail: American Foreign Service **Protective Association**
1620 L Street NW, Suite 800
Washington, DC 20036
Fax: (202) 775-9082
Online: https://www.afspa.org/secureform.cfm?FormName=Dental-Plan-Question