# 2022 FCG Retiree Health Benefit Enrollment

## ENROLLMENT TYPE

| | MEDICAL PLAN ENROLLMENT (Med) | DENTAL PLAN ENROLLMENT (Den) | VISION PLAN ENROLLMENT (Vis) |
|---|---|---|---|
| ○ New Enrollment<br>○ Mid-Year Enrollment Change<br>○ Open Enrollment Change<br>○ Cancel Coverage | ○ Cigna OAP In-Network Plan<br>○ Cigna TrueChoice Medicare (PPO)*<br>If on Medicare, MBI Number required: _____ | ○ Cigna Basic PPO Dental Plan<br>○ Cigna Enhanced PPO Dental<br>○ Cigna Dental HMO**<br>**HMO Provider #: _____ | ○ VSP Vision Plan |

## RETIREE INFORMATION

| Social Security Number | Retirement Date | | Effective Date/Change Date | |
|---|---|---|---|---|
| Last Name | First Name | MI | Date of Birth | Gender |
| Street Address *(*Residential address required if electing Cigna TrueChoice Medicare (PPO))* | | City | State | Zip |
| Primary Phone Number | Email Address | | Marital Status ○ Married ○ Single | |

## DEPENDENT INFORMATION (You may only include a spouse and/or dependent(s) who were enrolled at the time of retirement)

| Action | Last Name | First Name | MI | Sex | Birthdate | Relationship** | Plan Enrollment |
|---|---|---|---|---|---|---|---|
| ○ Enroll<br>○ Cancel Med \| Den \| Vis | | | | | | Spouse | ○ Cigna OAP In-Network Plan<br>○ Cigna True Choice Medicare (PPO)*<br>If on Medicare, MBI Number required: _____ |
| | Social Security Number: | | | | | | |
| ○ Enroll<br>○ Cancel Med \| Den \| Vis | | | | | | Child | Disabled Child? ○ Yes ○ No |
| | Social Security Number: | | | | | | |
| ○ Enroll<br>○ Cancel Med \| Den \| Vis | | | | | | Child | ○ Yes ○ No |
| | Social Security Number: | | | | | | |
| ○ Enroll<br>○ Cancel Med \| Den \| Vis | | | | | | Child | ○ Yes ○ No |
| | Social Security Number: | | | | | | |
| ○ Enroll<br>○ Cancel Med \| Den \| Vis | | | | | | Child | ○ Yes ○ No |
| | Social Security Number: | | | | | | |

**For court ordered dependent, legal documentation must be attached. If dependent does not reside with eligible retiree, please provide address on separate sheet.

## CONDITIONS OF ENROLLMENT

WARNING: IT IS A CRIME TO PROVIDE FALSE OR MISLEADING INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OF DEFRAUDING THE COMPANY OR ANY OTHER PERSON. PENALTIES INCLUDE INPRISONMENT AND/OR FINES. IN ADDITION, THE INSURANCE COMPANY MAY DENY INSURANCE BENEFITS IF FALSE INFORMATION MATERIALLY RELATED TO A CLAIM WAS PROVIDED BY THE APPLICANT.

I confirm that the information I have provided on this form is complete and accurate.

I understand that the benefit plan that I have selected may provide reimbursement for certain benefit related costs, which are more fully described in the current Benefits Summary and Certificates of Coverage. I understand there may be instances where treatment decisions made by my health care provider or me, or health care expenses which I have incurred, may not be covered by my benefit plan(s).

I acknowledge that I have received the "important information" statement, which is included on the back of this form.

Employee Signature: _____ Date: _____

## IMPORTANT INFORMATION

In order to make choices about your health care coverage and treatment, it is important for you to understand how your plan operates and how it may affect you. In an ever-changing environment, the information can never be complete and you are urged to contact the insurance company if the information in your Certificate of Coverage and other materials do not answer your questions.

Further medical and dental information is available at www.myCIGNA.com, by calling Cigna Customer Service at 1-800-244-6224, or through your employer.

Further vision information is available at www.VSP.com, by calling the VSP Customer Service at 1-800-877-7195, or through your employer.

1. The insurance company does not provide medical services or make treatment decisions. They help finance and/or administer the benefit plan in which you are enrolled. That means:
    - They make decisions about whether the benefit plan you choose will reimburse you for care that you may receive.
    - They do not decide what care you need or will receive. You and your physician make those decisions.

2. At Cigna HealthCare and VSP Vision Care, they are committed to maintaining the confidentiality of members' health information. They have established policies and safeguards to protect oral, written and electronic information across their organization. They will not use or disclose your confidential information for any purpose other than the purposes permitted by the HIPAA Privacy Rule without your written authorization. For example, they will not supply confidential information to another company for its marketing purposes or to a potential employer with whom you are seeking employment unless you authorize it.

3. Physicians and other providers in plan networks are independent contractors and are not the insurance company's employees or agents. The insurance company does not control nor do they have a right to control your physician's treatment plan.

4. If you are declining enrollment in an insurance plan because you are covered by another insurance plan, you may be able to enroll yourself and dependents at a later date if you or your dependents lose eligibility for that coverage. However, you must request enrollment from your employer within 30 days after the other coverage ends.

5. If you have a new dependent as a result of birth or adoption, or lose dependents as a result of death or divorce, you may enroll or disenroll the affected people from coverage, but only if you request the change within 30 days of the event that triggered the change. You also have the opportunity to make changes to your insurance during the annual open enrollment period. Contact your employer benefits representative for additional information about making changes to coverage.

6. I understand that the Certificate of Coverage and other documents, notices and communications, regarding my benefit plan may be transmitted electronically.

7. I understand that I have a continuing obligation to report changes in enrollment status (e.g., name and address changes, dependents reaching an age when they lose dependent status) to my employer benefits representative after I sign the enrollment form and during the time I am enrolled for coverage.

8. Your insurance is offered as a benefit from your employer. By enrolling for the benefit, you authorize any required premium contributions to be deducted from earnings, or agree to pay your portion during any periods when you are covered but not receiving earnings. Failure to pay your portion may result in your coverage being terminated.