



Not sure how to complete this form? Please contact VLCT Member Relations at 1-800-649-7915 for assistance.

ENROLLMENT/CHANGE FORM

Employer Name	CIGNA Acct #	Subscriber Social Security Number ____-____-____	Effective Date ____/____/____	Plan Type <input type="checkbox"/> Active <input type="checkbox"/> COBRA <input type="checkbox"/> MedAdv* (see below)
Subscriber Name (First Middle Last)	Sub Date of Hire ____/____/____	Sub Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Sub Date of Birth ____/____/____	*Medicare ID # ____-____-____ suffix
Subscriber Mailing Address (Street, City, State, Zip Code)				

Reason for Form (check all that apply)

<input type="checkbox"/> New Hire	<input type="checkbox"/> Cancel Subscriber	<input type="checkbox"/> Plan/Benefit Option Change
<input type="checkbox"/> Open Enrollment	<input type="checkbox"/> Transfer to COBRA	<input type="checkbox"/> Other/Reason _____
<input type="checkbox"/> Add Dependent(s)	<input type="checkbox"/> Transfer to Med Adv	_____
<input type="checkbox"/> Cancel Dependent(s)	<input type="checkbox"/> Address Change	_____

Spouse Name (First Middle Last)	Spouse Date of Birth ____/____/____	Spouse Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	
Dependent Name (First Middle Last)	Dependent DOB ____/____/____	Dependent Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Full Time Student? <input type="checkbox"/> Yes <input type="checkbox"/> No
	____/____/____	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Yes <input type="checkbox"/> No
	____/____/____	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Yes <input type="checkbox"/> No
	____/____/____	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Yes <input type="checkbox"/> No
	____/____/____	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Yes <input type="checkbox"/> No
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Benefit Plan (For new enrollees or subscriber plan changes, please check the appropriate plan code below.)

<table border="0"> <tr> <th>Plan Name</th> <th>Plan Code</th> </tr> <tr> <td>Med Adv High w/ RX</td> <td><input type="checkbox"/> VLCM1*</td> </tr> <tr> <td>Med Adv Med w/ RX</td> <td><input type="checkbox"/> VLCM2*</td> </tr> <tr> <td>Med Adv High no RX</td> <td><input type="checkbox"/> VLCM3*</td> </tr> <tr> <td>HP 10/20 A</td> <td><input type="checkbox"/> VHPD</td> </tr> <tr> <td>HP 10/20 B</td> <td><input type="checkbox"/> VHPE</td> </tr> <tr> <td>HP 10/20 C</td> <td><input type="checkbox"/> VHPF</td> </tr> <tr> <td>HP 20/30 A</td> <td><input type="checkbox"/> VHPG</td> </tr> <tr> <td>HP 20/30 B</td> <td><input type="checkbox"/> VHPH</td> </tr> <tr> <td>HSA \$1,500</td> <td><input type="checkbox"/> VHSA1</td> </tr> <tr> <td>HSA \$2,250</td> <td><input type="checkbox"/> VHSA2</td> </tr> <tr> <td>HSA \$3,000</td> <td><input type="checkbox"/> VHSA3</td> </tr> <tr> <td>Medicomp</td> <td><input type="checkbox"/> VTMD</td> </tr> </table>	Plan Name	Plan Code	Med Adv High w/ RX	<input type="checkbox"/> VLCM1*	Med Adv Med w/ RX	<input type="checkbox"/> VLCM2*	Med Adv High no RX	<input type="checkbox"/> VLCM3*	HP 10/20 A	<input type="checkbox"/> VHPD	HP 10/20 B	<input type="checkbox"/> VHPE	HP 10/20 C	<input type="checkbox"/> VHPF	HP 20/30 A	<input type="checkbox"/> VHPG	HP 20/30 B	<input type="checkbox"/> VHPH	HSA \$1,500	<input type="checkbox"/> VHSA1	HSA \$2,250	<input type="checkbox"/> VHSA2	HSA \$3,000	<input type="checkbox"/> VHSA3	Medicomp	<input type="checkbox"/> VTMD	<table border="0"> <tr> <th>Plan Name</th> <th>Plan Code</th> </tr> <tr> <td>OAP 100 B</td> <td><input type="checkbox"/> VLCTB</td> </tr> <tr> <td>OAP 100 C</td> <td><input type="checkbox"/> VLCTC</td> </tr> <tr> <td>OAP 200 A</td> <td><input type="checkbox"/> VLCTD</td> </tr> <tr> <td>OAP 200 B</td> <td><input type="checkbox"/> VLCTE</td> </tr> <tr> <td>OAP 200 C</td> <td><input type="checkbox"/> VLCTF</td> </tr> <tr> <td>OAP 500 A</td> <td><input type="checkbox"/> VLCTG</td> </tr> <tr> <td>OAP 500 B</td> <td><input type="checkbox"/> VLCTH</td> </tr> <tr> <td>OAP 500 C</td> <td><input type="checkbox"/> VLCTI</td> </tr> <tr> <td>Gold B</td> <td><input type="checkbox"/> VLCJ2</td> </tr> <tr> <td>Gold C</td> <td><input type="checkbox"/> VLCJ3</td> </tr> <tr> <td>OTHER _____</td> <td></td> </tr> </table>	Plan Name	Plan Code	OAP 100 B	<input type="checkbox"/> VLCTB	OAP 100 C	<input type="checkbox"/> VLCTC	OAP 200 A	<input type="checkbox"/> VLCTD	OAP 200 B	<input type="checkbox"/> VLCTE	OAP 200 C	<input type="checkbox"/> VLCTF	OAP 500 A	<input type="checkbox"/> VLCTG	OAP 500 B	<input type="checkbox"/> VLCTH	OAP 500 C	<input type="checkbox"/> VLCTI	Gold B	<input type="checkbox"/> VLCJ2	Gold C	<input type="checkbox"/> VLCJ3	OTHER _____	
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<p>If you are unsure of your group's particular plan names or benefit options, please contact VLCT Member Relations for assistance in completing the Benefit Plan portion of this form.</p>	<p>*Plan Name Description/Detail</p> <p>Letters A, B and C after the Plan Name represent the associated prescription drug option as follows:</p> <ul style="list-style-type: none"> A = \$100 Deductible 25% Coinsurance Prescription Drug Option B = \$50 Deductible 20% Coinsurance Prescription Drug Option C = \$50 Deductible \$5/\$10/\$25 Co-pay Prescription Drug Option
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Other Health Care Coverage (Please provide names of covered individuals, types of other coverage and effective dates)

Employer Signature	Date ____/____/____	Employee/Subscriber Signature	Date ____/____/____
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