INTERNATIONAL GROUP PLANS ENROLLMENT FORM

RESET FORM

A. GENERAL INFORMATION (ALL SPACES MUST BE COMPLETED)

Employer name: _____ Employer number: _____

Employee last name: _____ First: _____ MI: _____

Birthdate: _____ Social Security number: _____

Email: _____ Daytime phone: _____

Mailing address: _____

City: _____ State: _____ ZIP code: _____

Country of destination: _____ Airport code: _____ Effective date: _____

Gender: ☐ Male ☐ Female Marital status: ☐ Married ☐ Single

Employee classification: _____ Monthly Salary: $_____

Date of full-time employment: _____ Coverage effective date: _____

B. BENEFIT ELECTION

Medical

For myself: ☐ Yes ☐ No For my spouse: ☐ Yes ☐ No For eligible children: ☐ Yes ☐ No

Stateside coverage (select one): Select one _____

Overseas coverage (select one): Select one _____

[1]This plan does not constitute "creditable coverage" for Massachusetts residents.

[2]This plan is not considered "creditable coverage" under Medicare Part D for active participants age 65 and older.

Dental

For myself: ☐ Yes ☐ No For my spouse: ☐ Yes ☐ No For eligible children: ☐ Yes ☐ No

Stateside coverage (select one): Select one _____

Global coverage (select one): Select one _____

*Dental ID number required; please provide on page 2.

Vision

For myself: ☐ Yes ☐ No For my spouse: ☐ Yes ☐ No For eligible children: ☐ Yes ☐ No

Stateside coverage (select one): Select one _____

Term Life

Employee life (employer base life): ☐ Yes ☐ No (Amount: $_____)

Employee optional life insurance*: ☐ Yes ☐ No

Spouse life insurance (employer base): ☐ Yes ☐ No

Spouse optional life insurance*: ☐ Yes ☐ No

Child life insurance: ☐ Yes ☐ No

*Requires a separate *Evidence of Good Health Application*.

Continued on other side

Employee name: _____ Social Security number: _____

Accidental Death & Dismemberment

For myself: ☐ Yes ☐ No

Supplemental Accidental Death & Dismemberment

For myself: ☐ Yes ☐ No (Amount: $_____)

For spouse: ☐ Yes ☐ No (Amount: $_____) (Equals 50% of employee volume)

Long-term Disability

☐ Premier ☐ Choice ☐ Economy

Short-term Disability

☐ Premier ☐ Choice ☐ Economy

C. PARTICIPANT & DEPENDENT INFORMATION* (ONLY LIST FAMILY MEMBERS TO BE COVERED)

Last name	First name	MI	Social Security Number	Birthdate	Relationship	Sex M/F	Medical Y/N	Dental Y/N	Dental ID Number†	Vision Y/N

*Your spouse and children up to age 26 are eligible for coverage.
†Cigna Dental Care DHMO only.

D. REQUIRED SIGNATURES

I authorize my employer to arrange for me to be covered under the terms of the plans I have chosen. I also authorize my employer to make any required deductions from my earnings as my contribution to the cost of this coverage.

Employee signature: _____ Date: _____

Employer representative: _____ Date: _____