USI Affinity

CIGNA Dental Care DHMO Value Plan℠ Enrollment Form

For Patient Charge Schedule WAO09

Independent Business Owners Program

Office Use Only

Independent Business Owners, Spouses and Families
Please mail your completed enrollment form to USI Affinity,14 Cliffwood Ave, Suite 310, Matawan, NJ 07747.
Coverage becomes effective on the first day of the month following our receipt of your completed enrollment form and premium.

IBO #: _____ IBO Level: _____

Please Check One: ☐ New Enrollment ☐ Change, provide reason: _____

Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement or claim of an application containing any false or misleading information is guilty of insurance fraud. (In Florida, this is a felony of the third degree.)

General Information

_____
Applicant's Name

_____ _____ _____ _____ _____
Address Apt Number City State ZIP

Daytime Phone: _____ Home Phone: _____ Fax Number: _____

E-mail Address: _____ May we send you USI Affinity updates by e-mail? ■ Yes ☐ No

Handicapped dependents over the age of 26: Please attach a Physician's Statement

Complete for All Persons to Be Covered

Relationship	Name (including last if different)	Date of Birth	Gender	Social Security #	Dental Office Selection 1st Choice	Dental Office Selection 2nd Choice	Add or Cancel?
Self							
Spouse							
Child							
Child							
Child							
Child							
Child							
Child							
Child							

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which *is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation. (In Florida, this is a felony of the third degree. In New York, the civil penalty is not to exceed five thousand dollars and the stated value of the claim for each such violation. *In Nebraska, "is" is changed to "may be").

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 dependent to CIGNA Dental Health and Cigna Health and 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 Cigna Health and 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. California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance coverage. CIGNA Dental and Cigna Health and Life Insurance Company do not require such tests in any state as a condition of obtaining dental coverage.

Enclosed is my initial monthly premium (payable to USI Affinity) of

$ _____

I understand that I will continue to receive my premium statements monthly.
I have read and accepted the provisions printed above.

_____ _____
Signature of Applicant Date