USI Affinity

CIGNA Vision Enrollment Form

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 of claim or an application containing any false or misleading information is guilty of insurance fraud and subject to civil and criminal penalties. (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 #**	**Address** (if different)	**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 benefits to the participating provider.

I accept the coverage/insurance benefits provided by this group plan and authorize the processing of my enrollment in the coverage as indicated on this form. I accept responsibility of paying the entire cost of the coverage.

I authorize any participating provider office to release records and billing information concerning me or my dependents to Cigna Health & Life Insurance Company or its designee for purposes of plan administration or for the purpose of validating and determining benefits payable. I further authorize Cigna Health & Life Insurance Company or its designee to release any records or information concerning me or my dependents, 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 Health & Life Insurance Company and its designee do not require such tests in any state as a condition of obtaining coverage.

Billing Mode (check one): ☐ Monthly ☐ Quarterly ☐ Semi-annual ☐ Annual

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

$ _____

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

_____ _____
Signature of Applicant Date