Instructions

1. Your employer will complete section A.

2. Complete sections B through H.

3. If you are electing FSA Health, Limited Purpose or Dependent coverage please complete the separate Flexible Spending Account (FSA) Enrollment Form.

4. If you are electing dental coverage, complete the section entitled “DENTAL OPTIONS.”

5. If you are electing medical, complete the section entitled “MEDICAL OPTIONS.”

   - You have the option of selecting a Primary Care Physician (PCP) for yourself and each covered dependent. Your PCP can provide most medical services and can assist with hospital and specialist recommendations.

   If you need help selecting a PCP, contact Member Services.

6. Read the information on the back of the enrollment/change form.

7. Sign and date the enrollment/change.

We look forward to having you as our customer.

Administered by Cigna Health and Life Insurance Company

Cigna

Employer: Complete Section A **Employee:** Complete Section B-H

Enrollment/Change Form

A						
☐OPEN ENROLL ☐ CHANGE ☐ NEW ENROLL ☐ REINSTATE	EFFECTIVE DATE OF CHANGE ADD/CHANGE/CANCELLATION (MM/DD/CCYY) _____/_____/_____	EMPLOYER NAME Fine Laboratories ABC Company XXXXXXXX	DATE OF HIRE (MM/DD/CCYY) _____/_____/_____	PLAN NUMBER 00652708 000000 XXXXX	SUBGROUP	CLASS

B		
☐ SINGLE ☐ MARRIED _____/_____/_____ ☐ SEPARATED ☐ DIVORCED ☐ WIDOWED	TYPE OF CHANGE ☐ Add Dependent(s) * ☐ Demographics ☐ PCP Change ☐ Retirement * List Name(s) in Section C ☐ COBRA Continuation ☐ Other ______________________ Qualifying Event Date: _____/_____/_____	

C

EMPLOYEE NAME *(Last)*	*(First)*	SOCIAL SECURITY NUMBER - -	
EMPLOYEE DATE OF BIRTH (MM/DD/CCYY) _______/_______/_______	HOME PHONE (________)	EMAIL ADDRESS	
ADDRESS *(Street)*	*(City)*	*(State)*	*(Zip Code)*

☐ YES, I WOULD LIKE COVERAGE FOR MYSELF AND MY DEPENDENTS. (Specify last name if different from yours) Last Name First Name	Dependent Social Security Number	Date of Birth (MM/DD/CCYY)	Gen-der	Height	Weight	Coverage Selection	Full-Time Student?	Please list PCP ID below**	Dental Late Entrant?			
Employee	- -	/ /	☐M ☐F			☐Med ☐Den ☐Vis	☐ Yes ☐ No		☐ Yes ☐ No			
Dependent Relationship	- -	/ /	☐M ☐F			☐Med ☐Den ☐Vis	☐ Yes ☐ No		☐ Yes ☐ No			
Dependent Relationship	- -	/ /	☐M ☐F			☐Med ☐Den ☐Vis	☐ Yes ☐ No		☐ Yes ☐ No			
Dependent Relationship	- -	/ /	☐M ☐F			☐Med ☐Den ☐Vis	☐ Yes ☐ No		☐ Yes ☐ No			
Dependent Relationship	- -	/ /	☐M ☐F			☐Med ☐Den ☐Vis	☐ Yes ☐ No		☐ Yes ☐ No			

ADDITIONAL INFORMATION- * DEPENDENTS – If totally disabled prior to age 26, attach proof of disability for eligibility review. Dependents are covered under the medical plan to age 26. Proof of student status may be required for dental and/or vision coverage. **PCP ID is required when the Medical Option selected below is Cigna SureFit®. If a PCP is not selected during enrollment one will be assigned. Otherwise PCP is optional.

D	MEDICAL OPTIONS:	
☐	Cigna Consumer Advantage®/___________	
☐	PPO/___________	
☐	HSA (with Banking)/___________	
☐	HRA/___________	
☐	LocalPlus IN®/___________	
☐	Open Access Plus/___________	
☐	Indemnity/___________	
☐	LocalPlus®/___________	
☐	Cigna Care Network®/___________	
☐	Cigna SureFit®/___________	
☐	Decline Coverage	

E	DENTAL OPTIONS:		VISION OPTIONS:
☐	Cigna Dental Traditional/_______________	☐	Cigna Vision
☐	Cigna Dental PPO/_______________		
☐	Decline Coverage	☐	Decline Coverage

F	FLEXIBLE SPENDING ACCOUNT OPTIONS:
☐	Healthcare ***
☐	Dependent Care ***
	*** If you have elected one of the Flexible Spending Accounts in this section, please complete the corresponding enrollment form included in this package

G OTHER HEALTHCARE COVERAGE: Do you or your dependents have other health insurance under a group plan, HMO, or Medicare? ☐ Yes ☐ No If yes, please provide the following:

NAME OF PERSON COVERED	SOCIAL SECURITY NUMBER	EFFECTIVE DATE	MEDICARE Part A	MEDICARE Part B	MEDICAID	OTHER INSURANCE CARRIER
	- -	_____/_____/_____	☐	☐	☐	
	- -	_____/_____/_____	☐	☐	☐	

H	
	The information provided above is true and correct to the best of my knowledge, and I accept the provisions on the reverse side of this form which I have read and understand. **By my signature below, I acknowledge that I have read and understand the disclosure in this Enrollment/Change Form. I authorize the required payroll deduction for contributory benefits. I also represent that all information shown on this Enrollment/Change Form is correct. I understand that I will not be individually denied coverage or be individually charged different rates as a result of my answers. However, if I knowingly provide false information on this Questionnaire, I understand and agree that it may affect the payment of claims or result in termination of my/or my dependent(s) coverage.**
	EMPLOYEE SIGNATURE / DATE

PROVISIONS

- Cigna Dental PPO plans are administered by CHLIC, with network management services provided by Cigna Dental Health, Inc. and certain of its subsidiaries.
- I agree, for myself and my covered dependents, that, in the event any health services provided are the primary responsibility of any other party by way of other group health coverage or by the act or omission of another person, I will fully inform the health plan and will execute such assignments, liens or other documents which may be necessary to enable the health plan to recover the value of the services provided. I further agree that in the event I or any of my covered dependents collect benefits or damages from any other party who has primary responsibility for services provided by the health plan, I will immediately reimburse the health plan to the extent permitted by state law.

FRAUD WARNING

Any person who, knowingly and with intent to defraud any insurance company or other person: (1) files an application for insurance or statement of claim containing any materially false information; or (2) conceals for the purpose of misleading, information concerning any material fact thereto, commits a fraudulent insurance act.

AUTHORIZATION TO DEDUCT CONTRIBUTIONS

I authorize deductions from my earnings of the required contributions, if any, toward the cost of the coverage. This authorization applies only if employee contributions are required.

SPECIAL PROVISIONS FOR EMPLOYERS WITH SECTION 125 PLANS

By allowing an individual to enroll in the health plan, other than during the open enrollment period, Cigna Health and Life Insurance Company and its affiliates do not waive any terms of its contract. Further, by allowing an individual to enroll in the health plan, other than during an open enrollment period, Cigna Health and Life Insurance Company and its affiliates do not thereby express any opinion regarding the appropriateness of the change under Section 125 of the Internal Revenue Code or the terms of the employer's Section 125 Plan.

Flexible Spending Account (FSA) Enrollment Form

Directions to complete FSA enrollment form:

A. Please print and complete all employee informationunder section **A**, including your employer name and plan number

B. Complete the election information under section **B**

Note: Total annual elections are divided by the number of payroll occurrences during the remainder of the plan year

i. **Health Flexible Spending Account or Limited Purpose Flexible Sepnding Account-**
Reimbursement account to pay for eligible expenses not covered by your health plan for you, your spouse and any dependents

ii. **Dependent Care Flexible Spending Account-**
Reimbursement account to pay for dependent child care expenses, such as daycare

C. Sign and date the form in section **C** and return to your employer

Employer Use Only (missing information will delay setup)

1. **Employee Payroll frequency (please select one)**
   Monthly ☐ **Bi-weekly** ☐
   Semi-monthly ☐ **Weekly** ☐
   Other ☐_____

2. **FSA Election Effective Date** _____/_____/_____

A

Employee Name: _____ SSN/ID#: _____

Employee Address: _____
(city) (state) (zip code)

Employee Home Phone Number: _____ Date of birth (mm/dd/yy): _____/_____/_____

Employer Name: ABC Company Group Plan Number:_____

Date of Hire (mm/dd/yyyy) _____ Subgroup: _____ Class:_____

IMPORTANT NOTE: If you or your spouse have opened, or plan to open, an HSA, you may *not* elect a Health Flexible Spending Account. This does not apply to the Dependent Care Flexible Spending Account. If you or your spouse have opened, or plan to open, an HSA, you may elect a Limited Purpose Flexible SpendingAccount.

B

HEALTH FLEXIBLE SPENDING ACCOUNT

Your Annual Contribution $_____ (Maximum is set by your Employer but cannot be more than $2,600.)

LIMITED PURPOSE FLEXIBLE SPENDING ACCOUNT

Your Annual Contribution $_____ (Maximum is set by your Employer but cannot be more than $2,600.)

AutoPay **I choose to elect AutoPay (if offered under my Employer's Plan)** ☐ **Yes** ☐ **No**

By signing below, I hereby certify that (1) I have read and understand the AutoPay terms and conditions as explained on Page 2 of this form; (2) I hereby authorize CIGNA to reimburse me through my Health or Limited Purpose Flexible Spending Account for all allowable charges on claims which are considered, but not fully paid, by my Employer's health plan offered through CIGNA; (3) I understand and agree that all of my Health or Limited Purpose FSA claims processed under the AutoPay feature are considered to be submitted to the Health or Limited Purpose FSA plan on the date a final claim decision under my employer's health plan is forwarded to the Health or Limited Purpose FSA plan's clai6ms administrator; (4) the AutoPay process will stop once my Health or Limited Purpose FSA benefit balance has been exhausted; (5) I meet the eligibility requirements set forth on page 2 of this form; and (6) with respect to all my Health or Limited Purpose FSA claims processed under the AutoPay feature,
I certify that: I (and/or my spouse and/or dependent) have incurred the expenses for reimbursement from my health or Limited PurposeFSA; these expenses were not reimbursed, and are not reimbursable by any other benefit plan; and I (we) will not claim the expenses reimbursed through my Health or Limited Purpose FSA as deductions or credits when filing my (our) individual tax return. I agree to refund the plan for any Health or Limited Purpose FSA reimbursement I receive that fails to meet any of the conditions stated in (5) and (6).

DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT

Your Annual Contribution $_____ (Maximum $5,000 if filing jointly, filing separately, $2,500 maximum)

C

I hereby authorize my election(s) and pre-tax salary contribution(s) for the account(s) designated above for the plan year. I understand that this election is an annual election and cannot be changed during the plan year except in the case of a qualified change in family status. I understand that any unused balances in my Health or Limited Purpose Flexible Spending Account beyond the maximum I can carryover at the end of the plan year, or including the incurred claims grace period if applicable, shall be forfeited. I understand that any unused balances in my Dependent Care Flexible Spending Account at the end of the plan year, including the incurred claims grace period if applicable, shall be forfeited. If I have elected AutoPay, I certify that I meet the eligibility requirements set forth on Page 2. Further, I understand that I must *revoke* such election if at any time during the plan year if I fail to meet the eligibility requirements.

Employee Signature:_____ **Date:** _____

Health Flexible Spending Account AutoPay Guidelines

If AutoPay is offered by your employer, and is elected by you on Page 1, claims under your Health or Limited Purpose Flexible Spending Account will be processed as described below.

1. What is AutoPay?

AutoPay allows a Health or Limited Purpose FSA participant who has a health care and/or dental or vision claim submitted to the employer's health plan to avoid having to also submit a separate request for reimbursement under the Health or Limited Purpose FSA for any remaining unpaid portion of such claim. In other words, after his/her health care and/or dental and vision claim has been processed under the employer's plan, the result of such claim payment will be automatically forwarded to the FSA claim department so that any claim portion remaining unpaid under the employer's health plan (because of deductible, coinsurance or co-pay requirements, etc.) can be considered for reimbursement under his/her Health or Limited Purpose FSA.

2. Will I be eligible to elect AutoPay?

You are eligible ***only*** if:

a) you are enrolled under your employer's Health FSA or Limited Purpose FSA; and
b) you are covered under your employer's CIGNA health plan; and
c) neither you, your spouse, nor your dependent has secondary coverage under any other medical or health plan (e.g., an employer's plan of your spouse or your parent); and
d) none of the persons, if any, covered with you under your employer's health plan fails to qualify as your spouse or tax dependent.

Claims reimbursed by your Health or Limited Purpose Flexible Spending Account *and* other coverage, could result in adverse tax consequences for your Health or Limited Purpose Flexible Spending Account.

3. What is a Limited Purpose Flexible Saving Account?

A Limited Purpose FSA is designed to meet the HSA guidelines and is used to reimburse eligible Vision and Dental expenses. Customers with the HSA plan can only enroll in the Limited Purpose FSA. They cannot enroll in the full purpose FSA Health Care Account.

4. Can I still submit a paper claim to request Health or Limited Purpose FSA reimbursement for expenses that were not submitted as claims under my employer's health plan?

Yes, you can still submit paper claims to request Health or Limited Purpose FSA reimbursement directly for eligible health care expenses that you incur outside your employer's health plan.

FSA Worksheet

Your Eligible Expenses

1. Eligible Health Flexible Spending Account Expenses

- Deductibles, Co-payments $ _____
- Out-of-pocket costs for eligible expenses that will not be covered under any health plan or are subject to coinsurance cost sharing:
  - Hospital expenses _____
  - Physician expenses _____
  - Dental expenses _____
  - Vision and eye care, i.e., exams, glasses, contacts, radial keratotomies _____
  - Hearing expenses, i.e., exams, hearing aids _____
  - Physical examinations, i.e., annual checkups, school exams _____
  - Psychiatric counseling _____
  - Chiropractic and acupuncture treatment _____
  - Prescription drugs, insulin, contraceptives _____
  - Drug or alcohol treatment _____
  - *Other* health care-related expenses _____
- Eligible over-the-counter medications _____

Total Estimated Eligible Health Flexible Spending Account Expenses $ _____

2. Eligible Limited Purpose Flexible Spending Account Expenses

- Vision and Dental Deductibles, Co-payments $ _____
- Out-of-pocket costs for eligible expenses that will not be covered under any health plan or are subject to coinsurance cost sharing:
  - Dental expenses _____
  - Vision and eye care, i.e., exams, glasses, contacts _____

Total Estimated Eligible Limited Purpose Flexible Spending Account Expenses $ _____

3. Eligible Dependent Care Flexible Spending Account Expenses

Estimate the total amount you pay during the year for daycare provided for your child or elderly or disabled family member. Then enter how much of that amount you want to redirect in the Dependent Care Flexible Spending Account.

Total Estimated Dependent Care Flexible Spending Account Expenses $ _____

Based on your elections (on Page 1) and subject to the Plan's rules and maximum benefits provisions, your payroll administrator will calculate your pre-tax deduction per paycheck for Health and Limited Purpose Flexible Spending Account and Dependent Care Flexible Spending Account expenses.

Eligible expenses are determined by the applicable provisions of the plan, based on IRS guidelines for FSA programs under Sections 105, 125 and 129 of the Internal Revenue Code.

An electronic version of this calculator is also available on the web at myCigna.com.

DISCRIMINATION IS AGAINST THE LAW

Medical coverage

Cigna complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.
Cigna:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact customer service at the toll-free number shown on your ID card, and ask a Customer Service Associate for assistance.

If you believe that Cigna has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance by sending an email to ACAGrievance@Cigna.com or by writing to the
following address:

Cigna
Nondiscrimination Complaint Coordinator
PO Box 188016
Chattanooga, TN 37422

If you need assistance filing a written grievance, please call the number on the back of your ID card or send an email to ACAGrievance@Cigna.com. You can also file a civil rights complaint with the U.S. Department of Health and Human Services,
Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, DC 20201
1.800.368.1019, 800.537.7697 (TDD)
Complaint forms are available at
http://www.hhs.gov/ocr/office/file/index.html.

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Proficiency of Language Assistance Services

English – ATTENTION: Language assistance services, free of charge, are available to you. For current Cigna customers, call the number on the back of your ID card. Otherwise, call 1.800.244.6224 (TTY: Dial 711).

Spanish – ATENCIÓN: Hay servicios de asistencia de idiomas, sin cargo, a su disposición. Si es un cliente actual de Cigna, llame al número que figura en el reverso de su tarjeta de identificación. Si no lo es, llame al 1.800.244.6224 (los usuarios de TTY deben llamar al 711).

Chinese – 注意：我們可為您免費提供語言協助服務。對於 Cigna 的現有客戶，請致電您的 ID 卡背面的號碼。其他客戶請致電 1.800.244.6224 （聽障專線：請撥 711）。

Vietnamese – XIN LƯU Ý: Quý vị được cấp dịch vụ trợ giúp về ngôn ngữ miễn phí. Dành cho khách hàng hiện tại của Cigna, vui lòng gọi số ở mặt sau thẻ Hội viên. Các trường hợp khác xin gọi số 1.800.244.6224 (TTY: Quay số 711).

Korean – 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 현재 Cigna 가입자님들께서는 ID 카드 뒷면에 있는 전화번호로 연락해주십시오. 기타 다른 경우에는 1.800.244.6224 (TTY: 다이얼 711)번으로 전화해주십시오.

Tagalog – PAUNAWA: Makakakuha ka ng mga serbisyo sa tulong sa wika nang libre. Para sa mga kasalukuyang customer ng Cigna, tawagan ang numero sa likuran ng iyong ID card. O kaya, tumawag sa 1.800.244.6224 (TTY: I-dial ang 711).

Russian – ВНИМАНИЕ: вам могут предоставить бесплатные услуги перевода. Если вы уже участвуете в плане Cigna, позвоните по номеру, указанному на обратной стороне вашей идентификационной карточки участника плана. Если вы не являетесь участником одного из наших планов, позвоните по номеру 1.800.244.6224 (TTY: 711).

Arabic – برجاء الانتباه خدمات الترجمة المجانية متاحة لكم. لعملاء Cigna الحاليين برجاء الاتصال بالرقم المدون علي ظهر بطاقتكم الشخصية. او اتصل ب 1.800.244.6224 (TTY: اتصل ب 711).

French Creole – ATANSYON: Gen sèvis èd nan lang ki disponib gratis pou ou. Pou kliyan Cigna yo, rele nimewo ki dèyè kat ID ou. Sinon, rele nimewo 1.800.244.6224 (TTY: Rele 711).

French – ATTENTION: Des services d'aide linguistique vous sont proposés gratuitement. Si vous êtes un client actuel de Cigna, veuillez appeler le numéro indiqué au verso de votre carte d'identité. Sinon, veuillez appeler le numéro 1.800.244.6224 (ATS : composez le numéro 711).

Portuguese – ATENÇÃO: Tem ao seu dispor serviços de assistência linguística, totalmente gratuitos. Para clientes Cigna atuais, ligue para o número que se encontra no verso do seu cartão de identificação. Caso contrário, ligue para 1.800.244.6224 (Dispositivos TTY: marque 711).

Polish – UWAGA: w celu skorzystania z dostępnej, bezpłatnej pomocy językowej, obecni klienci firmy Cigna mogą dzwonić pod numer podany na odwrocie karty identyfikacyjnej. Wszystkie inne osoby prosimy o skorzystanie z numeru 1 800 244 6224 (TTY: wybierz 711).

Japanese – 注意事項：日本語を話される場合、無料の言語支援サービスをご利用いただけます。現在のCignaのお客様は、IDカード裏面の電話番号まで、お電話にてご連絡ください。その他の方は、1.800.244.6224（TTY: 711）まで、お電話にてご連絡ください。

Italian – ATTENZIONE: Sono disponibili servizi di assistenza linguistica gratuiti. Per i clienti Cigna attuali, chiamare il numero sul retro della tessera di identificazione. In caso contrario, chiamare il numero 1.800.244.6224 (utenti TTY: chiamare il numero 711).

German – ACHTUNG: Die Leistungen der Sprachunterstützung stehen Ihnen kostenlos zur Verfügung. Wenn Sie gegenwärtiger Cigna-Kunde sind, rufen Sie bitte die Nummer auf der Rückseite Ihrer Krankenversicherungskarte an. Andernfalls rufen Sie 1.800.244.6224 an (TTY: Wählen Sie 711).

Persian (Farsi) – توجه: خدمات کمک زبانی، به صورت رایگان به شما ارائه می‌شود. برای مشتریان فعلی Cigna، لطفاً با شماره‌ای که در پشت کارت شناسایی شماست تماس بگیرید. در غیر اینصورت با شماره 1.800.244.6224 تماس بگیرید (شماره تلفن ویژه ناشنوایان: شماره 711 را شماره‌گیری کنید).

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