# CIGNA ENROLLMENT / CHANGE FORM

| **Group Number:** *3211196* | **Effective Date: 07/01/2026** *(Return form to Heather Orosz, Benefits Office)* |
|---|---|
| **Employer Name:** *Simsbury Public Schools* | **Employer Address:** *933 Hopmeadow St, Simsbury, CT 06070* |
| **Employee Branch/Division/Class:** *SEA - Teachers* | |

**Choose Plan Type:** *(Choose only one)*

| High Deductible Health Plan with Health Savings Account – HDHP/HSA | High Deductible Health Plan with Health Reimbursement Account – HDHP/HRA |
|---|---|
| ☐ | ☐ |

*(Please Print)*

| ***EMPLOYEE LAST NAME:*** | | ***EMPLOYEE FIRST NAME:*** | ***MI*** | ***SOCIAL SECURITY NUMBER*** |
|---|---|---|---|---|
| ***EMPLOYEE DATE OF BIRTH*** *(MM-DD-YYYY)* | ***HOME PHONE*** ( ) | ***WORK PHONE*** ( ) | ***HOME E-MAIL ADDRESS*** | ***EMPLOYEE ID NUMBER*** |
| ***STREET ADDRESS:*** | | ***CITY*** | ***STATE*** | ***ZIP CODE*** |

**I WOULD LIKE COVERAGE FOR ME AND MY DEPENDENTS**
*(Specify last name if different from yours)*

| ***LAST NAME, FIRST NAME, MI*** | **SOCIAL SECURITY NUMBER** *(Required)* | **DATE OF BIRTH** *(MM-DD-YYYY)* | **GENDER** |
|---|---|---|---|
| *Employee* | | | |
| *Spouse* | | | |
| *Dependent** | | | |
| *Dependent** | | | |
| *Dependent** | | | |
| *Dependent** | | | |

| **EMPLOYEE'S SIGNATURE / DATE** | **EMPLOYER'S SIGNATURE / DATE** |
|---|---|
| | |

**Dependents – Dependents are covered under the medical plan up to age 26.  If totally disabled prior to dependent eligibility end date, attach proof of disability for eligibility review.*