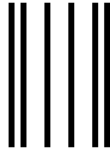
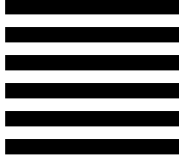




BUSINESS REPLY MAIL

FIRST CLASS MAIL PERMIT NO. 4570 FT LAUD., FL

POSTAGE WILL BE PAID BY ADDRESSEE

ATTN: ENROLLMENT PROCESSING
CIGNA Dental
PO BOX 189060
PLANTATION FL 33318-9821

CIGNA Dental refers to the following operating subsidiaries of CIGNA Corporation: Connecticut General Life Insurance Company and CIGNA Dental Health, Inc., and its operating subsidiaries. The CIGNA Dental Care plan is provided by CIGNA Dental Health Plan of Arizona, Inc., CIGNA Dental Health of California, Inc., CIGNA Dental Health of Colorado, Inc., CIGNA Dental Health of Delaware, Inc., **CIGNA Dental Health of Florida, Inc., a Prepaid Limited Health Services Organization licensed under Chapter 636, Florida Statutes**, CIGNA Dental Health of Kansas, Inc. (Kansas and Nebraska), CIGNA Dental Health of Kentucky, Inc., CIGNA Dental Health of Maryland, Inc., CIGNA Dental Health of New Jersey, Inc., CIGNA Dental Health of New Mexico, Inc., (available only in Albuquerque and Santa Fe), CIGNA Dental Health of North Carolina, Inc., CIGNA Dental Health of Ohio, Inc., CIGNA Dental Health of Pennsylvania, Inc., CIGNA Dental Health of Texas, Inc., and CIGNA Dental Health of Virginia, Inc. In other states, the CIGNA Dental Care plan is underwritten by Connecticut General Life Insurance Company and administered by CIGNA Dental Health, Inc.

561210c Rev.10-00

Dental Office Selection Card

CIGNA Dental

COMPANY NAME

COVERED MEMBERS: *Please refer to completion instructions on right side of card.*

What is your primary language? ______________________

Do you have a disability affecting your ability to communicate or read? ☐ Yes ☐ No

Members	**Last Name, First Name**	**Date of Birth**	**Dental Office Selection First Choice**	**Dental Office Selection Alternate Choice**
Self Soc. Sec. #	___ - __ - ____	/ /		
Spouse Soc. Sec. #	___ - __ - ____	/ /		
Child Soc. Sec. #	___ - __ - ____	/ /		
Child Soc. Sec. #	___ - __ - ____	/ /		
Child Soc. Sec. #	___ - __ - ____	/ /		
Child Soc. Sec. #	___ - __ - ____	/ /		

Fold Here & Tape Closed

I accept the coverage/insurance benefits provided by this group dental plan and authorize the processing of my enrollment in the dental coverage. I authorize deduction from my earnings of the required contributions, if any, toward the cost of the coverage.

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 dependents to CIGNA Dental Health for purposes of plan administration. I further authorize CIGNA Dental Health 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 Health and Connecticut General Life Insurance Company do not require such tests in any state as a condition of obtaining dental coverage.

SIGNATURE ______________________________ DATE ______________

Subscriber Address:

To select your dental office, please return this card immediately.

(Detach here before mailing)

CIGNA Dental Care Dental Office Selection Card

Use this card to choose your primary dentist from our dental HMO-type network.

Instructions:

1. Please write company name in box.
2. Fill in the "Covered Members" section.
3. Each family member should select a dental office from the network directory. Write the dental office numbers in the space indicated (both a first and an alternate choice).
4. Tear off this instruction portion at the perforation and keep it for your records. Record your dental office selections in the space provided. Mail the card to CIGNA Dental.

To change your dental office, call Member Services to speak to a representative, or follow the steps to use our automated Quick Transfer option. In most cases, the change will take effect on the first day of the following month.

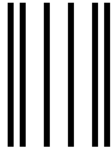
CIGNA Dental

If you do not choose a dental office or both your first and alternate choices are not available, the closest available dental office to your home will be selected for you and your enrolled dependents.

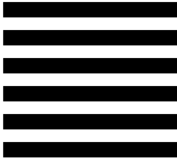
Questions? Call Member Services or visit the CIGNA Dental Website at *www.cigna.com/dental.*

Your CIGNA Dental Care Network Office selections are:

	First Choice	**Alternate Choice**
Self		
Spouse		
Child		
Child		
Child		
Child		



NO POSTAGE
NECESSARY IF
MAILED IN THE
UNITED STATES



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USE THIS PAGE TO OVERLAY BRM ON PAGE 1
FIM CODES TO BLEED OFF OF TOP OF CARD