Allegiance℠ by Cigna Healthcare

PREMIUM ENROLLMENT FORM

Please print clearly *(For Employer use only. DO NOT forward to Allegiance.)*

EMPLOYER:	PLAN YEAR:		
DIVISION:	EFFECTIVE DATE(mm/dd/yy)		
EMPLOYEE NAME:	☐OPEN ENROLLMENT ☐NEW HIRE ☐CHANGE*		
SSN:	BIRTH DATE (mm/dd/yyyy):		
MAILING ADDRESS:	PHONE:	☐M ☐F	☐Married ☐Single
CITY: STATE: ZIP:	EMAIL:		

PREMIUM ELECTION AUTHORIZATION

PLAN/ACCOUNT TYPE	MONTHLY PREMIUM				TOTAL ANNUAL ELECTION
_____	_____	x	12	=	_____
_____	_____	x	12	=	_____
_____	_____	x	12	=	_____
_____	_____	x	12	=	_____
_____	_____	x	12	=	_____

CERTIFICATION (Please read before signing)

I certify that these are my benefit elections and that:

1. I am aware that premium and other contributions made under this plan are the property of my Employer and will be used to purchase the elected coverage and cannot be refunded
2. I further understand that this agreement cannot be revoked or changed during the Plan Year unless I experience a qualified change in status that allows for such event.
3. I authorize my Employer to adjust my salary reductions upward or downward to cover my revised share of the premium.
4. This agreement shall continue from year to year unless revoked or changed in writing by me before the commencement of a new Plan Year.

Both an employee signature and company authorization are required for enrollment to be completed.

Signed: _____ Date: _____

Company Authorization: _____ Date: _____

*If this is an election change, please indicate the qualifying event:

_____ HR initials _____

2024

For Allegiance use only

Group Number: _____ Date Completed: _____ Entered By (initials): _____