



**SECTION II: SPECIFICATIONS FOR COVERAGE**

**HEALTH BENEFITS** (check one)

STATE MANDATED:  SM HMO  SM OPT A (INDEMNITY)  SM OPT B (INDEMNITY)  
 SM OAP OPT C  SM OAP OPT D  SM OPT E (INDEMNITY)

OAP PLANS:  A  A-1  C  D  
 E  F  G  
 J  K  L  
 M  N  O

**SECTION III: ALL QUESTIONS MUST BE ANSWERED**

1. Is there any Group Health Plan: Now in force and to be continued?  Yes  No  
 Currently being applied for?  Yes  No

If Yes: Identify the Name of the Group Health Plan: \_\_\_\_\_

Give a Description of the plan(s): \_\_\_\_\_

Name of Insurance Carrier(s): \_\_\_\_\_

2. Name of Present or Prior Group Carrier: \_\_\_\_\_

Effective Date of Prior Coverage: \_\_\_\_\_ Cancellation/Termination Date: \_\_\_\_\_

3. Is the coverage applied for in this application replacing other group insurance?  Yes  No

If Yes, give reason: \_\_\_\_\_

4. Has your firm been uninsured for 3 or more months prior to application?  Yes  No

5. What forms of insurance are now or were in force?  Health Benefits  Prescription Drugs  
 (attach copies of Booklet/Certificate and most recent Billing Statement)

6. Are extended benefits provided in case of termination of health benefits?  Yes  No

7. To the best of your knowledge are there any current or former employees or their eligible dependents whose health insurance is being continued?  Yes  No

**Please provide the following information for each current/former employee or dependent on health continuations.**

Name of Employee/Dependent	Date of Birth	Type of Continuation State/Federal/Extended Benefits	Reason for Termination/Disability/Other	Continuation Dates	
				Start	End

*If additional space is needed, attach a separate sheet, signed and dated.*

8. To the best of your knowledge:  
 Are any employees or dependents presently incapacitated?  Yes  No  
 Are any dependent children incapable of self-support due to a physical or mental disability?  Yes  No

**Additional space to explain if items 1, 2 or 3 were answered "Yes". Refer to the question number and give details including names, where appropriate.**

9. Does the employer participate in an arrangement with a Professional Employer Organization?  Yes  No  
 (Refer to Advisory Bulletin 00-SEH-02 if you need information concerning what constitutes Professional Employer Organizations.)

**SECTION IV: AGENT/PRODUCER INFORMATION**

Broker Name: \_\_\_\_\_ CIGNA ID #: \_\_\_\_\_

Agency Name: \_\_\_\_\_

**SECTION V: SIGNATURE**

It is understood that, except as provided under applicable regulations, no individual shall become insured while not actively at work on a full-time basis, and only full-time employees are eligible. A full-time employee is one who regularly works at least 25 hours per week at his employer's place of business. It is further understood that no agent has power on behalf of CIGNA HealthCare of New Jersey, Inc. to make or modify any request or application for insurance or to bind CIGNA HealthCare of New Jersey Inc. by making any promise or representation or by giving or receiving any information.

It is further understood that no insurance will be effective unless and until the application is accepted in writing by CIGNA HealthCare of New Jersey, Inc. Final rates will be based on enrollment data as of the Policy effective date. No contract of insurance is to be implied in any way on the basis of the completion and/or submission of this application.

Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

Dated at: \_\_\_\_\_ on \_\_\_\_\_

\_\_\_\_\_  
*Print name of Officer, Partner or Proprietor*

\_\_\_\_\_  
*Signature of Officer, Partner or Proprietor*

\_\_\_\_\_  
*Witness to Signature*

**NOTE:** If there are any modifications to the statements and answers given in this application (i.e., crossed out, whited-out, erased information), the applicant must attest to the modifications by giving a complete signature in the margin near the modification.