

Return Forms To:

SDCERS

401 West A Street, Suite 400

San Diego, CA 92101

City of San Diego Cigna Election Form

Enrollment Disenrollment

Employee Information					
Last Name		First Name			MI
Birth Date (MM/DD/YYYY) / /	Gender <input type="radio"/> Male <input type="radio"/> Female	Social Security Number			
Residential Address (<input type="radio"/> This is a change of address)		City	State	Zip	
Mailing Address (if different from residential address)		City	State	Zip	
Home Phone	PCP ID #		Medicare ID Claim # (Required if Medicare Eligible)		
Medical Plan Options					
Cigna Non-Medicare Plans		<input type="radio"/> HMO <input type="radio"/> HMO Select <input type="radio"/> Open Access Plus		Cigna Medicare Plans	<input type="radio"/> HMO COB <input type="radio"/> Medicare Surround
Enrolling Dependent Information					
Last Name		First Name			MI
Birth Date (MM/DD/YYYY) / /	Gender <input type="radio"/> Male <input type="radio"/> Female	Dependent Type <input type="radio"/> Spouse <input type="radio"/> Dependent	Social Security Number		
Residential Address (<input type="radio"/> This is a change of address)		City	State	Zip	
Mailing Address (if different from residential address)		City	State	Zip	
Home Phone	PCP ID #		Medicare ID Claim # (Required if Medicare Eligible)		
Medical Plan Options					
Cigna Non-Medicare Plans		<input type="radio"/> HMO <input type="radio"/> HMO Select <input type="radio"/> Open Access Plus		Cigna Medicare Plans	<input type="radio"/> HMO COB <input type="radio"/> Medicare Surround

Coverage Effective Date: _____

Signature _____

Date: _____