Insured and/or Administered by
Connecticut General Life Insurance Company
CIGNA HealthCare
OPEN ACCESS PLUS

STANDARD PLAN
HIGH PLAN

Enrollment/Change Form

A	☐ OPEN ENROLL ☐ NEW ENROLL ☐ CHANGE ☐ REINSTATE	**EMPLOYER NAME:** THE CHURCHILL BENEFIT CORPORATION DBA YURCOR	**EMPLOYER ADDRESS:** *150 East Palmetto Park Road,* *Boca Raton FL 33432*
	CIGNA ACCOUNT NUMBER	**DATE OF HIRE**	**EFFECTIVE DATE**

B	**EMPLOYEE NAME** (Last) (First) (M.I.)				**SOCIAL SECURITY NO.**	
	EMPLOYEE DATE OF BIRTH	**HOME PHONE** ( )	**WORK PHONE** ( )	**EMAIL ADDRESS**:		
	ADDRESS					
	I WOULD LIKE COVERAGE FOR ME AND MY DEPENDANTS(*Specify of last name is different than yours)* Last Name First Name M.I.	**DEPENDENT SOCIAL SECURITY NO.**	**DATE OF BIRTH** MM DD CCYY	**GENDER**	**FULL TIME STUDENT?**	
	Employee			☐ M ☐ F	YES	NO
	Spouse			☐ M ☐ F		
	Dependent* Relationship			☐ M ☐ F	☐	☐
	Dependent* Relationship			☐ M ☐ F	☐	☐
	Dependent* Relationship			☐ M ☐ F	☐	☐
	* **DEPENDENTS**- if full time student and age 19 or over, attach proof verifying credit hours.					

C	**OTHER HEALTH CARE COVERAGE:** *Do you or your dependents have other health insurance under a group plan, HMO, or Medicare?* ☐ *YES if yes, please provide the following* ☐ *NO*					
	NAME OF PERSON COVERED	**SOCIAL SECURITY NO.**	**EFFECTIVE DATE**	**MEDICARE** *Part A* *Part B*	**MEDICAID**	**OTHER ISURANCE CARRIER**
				☐ ☐	☐	☐

D	**SIGNATURE** -*the information provided above is true and correct to the best of knowledge*	
	EMPLOYEE SIGNATURE	*DATE*