This form must be received by the Benefits Department within 31 calendar days of the mid-year election change event or hire date, whichever is applicable.

To go to the top of the form press TAB.

SF 4400-MED (9-2004) Supersedes (2-2004) issue

UCI

Medical Insurance Enrollment Form

For Benefits Use Only

Coverage effective date: ______________

SNL database: ______________ Rx: __________

PLEASE PRINT CLEARLY.

A) Medical Plan Information:

Select the plan you wish to enroll in or the plan you are currently enrolled in:

☐ Top ☐ Intermediate ☐ Basic ☐ CIGNA

B) Enrollment Information:

I am a(n): *(Check one)* ☐ Employee or Student employee ☐ Retiree ☐ Surviving Spouse ☐ COBRA participant

This is a(n): *(Check one)* ☐ New Enrollment ☐ Addition ☐ Reinstatement

Type of enrollment: *(Check one)* ☐ New Hire ☐ Marriage ☐ Birth ☐ Adoption Placement[2] ☐ Domestic Partner/Dependent[1]

☐ Other, *Please Describe:* ______________________________

Qualifying event date (e.g., hire date, marriage date, etc.) ______________________________

[1]include Domestic Partnership Affidavit with this form
[2]include adoption papers with this form

C) Primary member Information:

Last Name First Name Middle Initial Date of Birth Social Security Number

Street Address City, State (Please Abbreviate) Zip Code

Home Phone Work Phone

Union Affiliation *(Check One)*:
☐ None ☐ MTC ☐ OPEIU ☐ SPA

D) Dependent Information: Please list below each family member you wish to cover. Note: If you are currently covered and are only adding a new family member or new family members to your plan, you only need to list the new addition(s) to your plan. If you have more than five children, please obtain an additional enrollment form and attach it to this form.

Last Name, First Name, M.I.	Relationship to Employee	SSN	Sex	Birth Date

E) Other Health Care Coverage:

Do you or your dependents have other group health care coverage? ☐ Yes ☐ No

If **yes**, please provide the following information:

Name(s) of person/people covered: ______________________________

Primary member ID number: ______________ Employer name: ______________

Insurance Company name & address: ______________________________

F) Employee's Signature: I understand that if a covered individual is injured through the act or omission of another, United of Omaha Life Insurance Company and CIGNA health plan, require reimbursement for the benefits. I agree that the information provided above is true and correct to the best of my knowledge.

Employee Signature **Date**