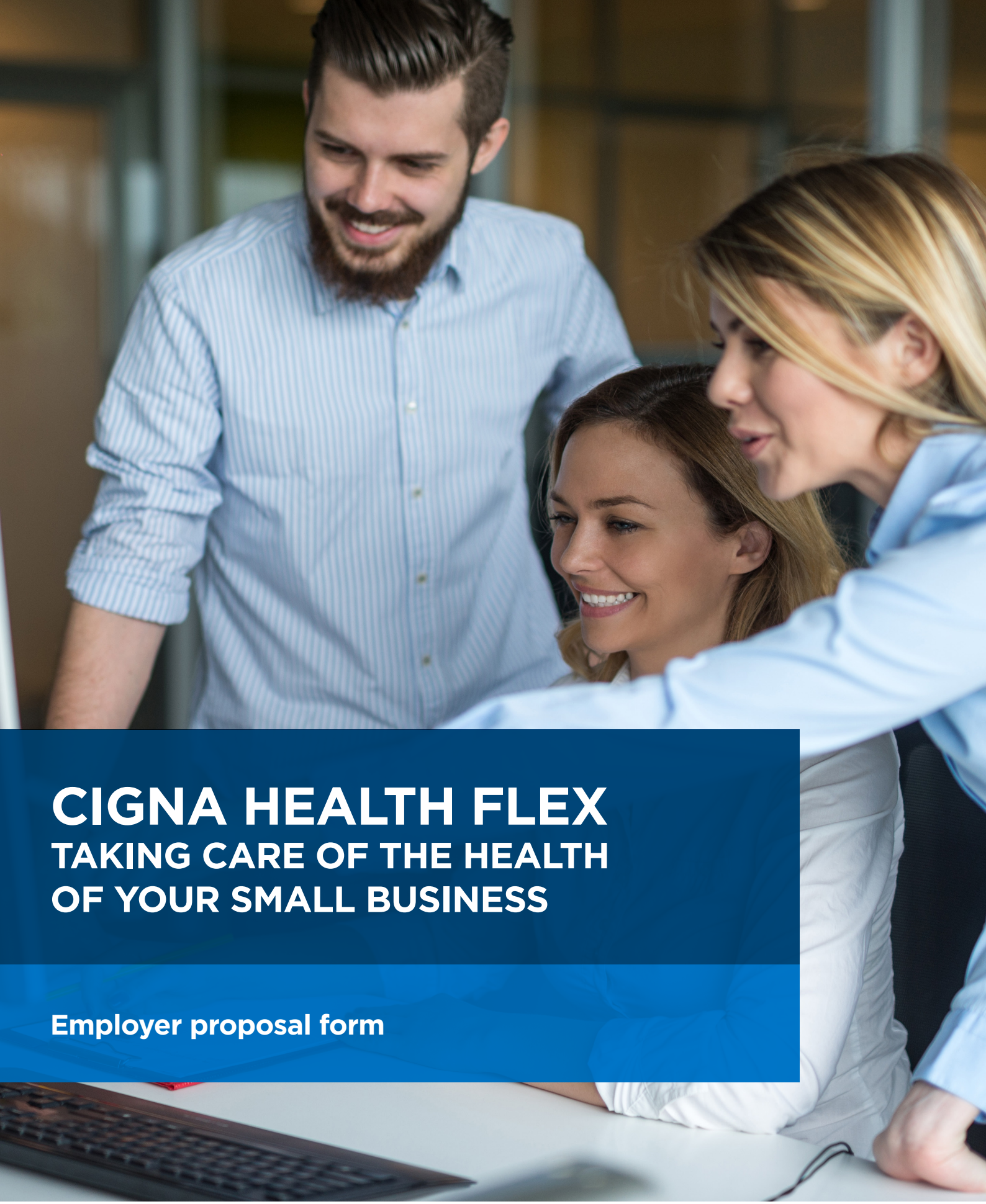

CIGNA HEALTH FLEX

TAKING CARE OF THE HEALTH OF YOUR SMALL BUSINESS

Employer proposal form

Together, all the way.℠

Cigna®

Employer proposal form - please make sure you complete all sections of this form.
Failure to do so will delay set up of your healthcare plan.

Please complete this form and return this to: cbc@cigna.com or post to: Telesales team, 1 Knowe Road, Greenock, PA15 4RJ

Please remember to:
- include any additional information as detailed in the 'Underwriting options' section of this form.
- provide employee email addresses.

COMPANY DETAILS

Company name			
Nature of business			
Total number of employees in company			
Business address			
		Postcode	
Company registration number			
Registered address (if different)			
		Postcode	
Name(s) & address(es) of any subsidiary and associated employers (if to be included in this plan)			
Subsidiary company name			
Company registration number			
Address			
		Postcode	
Subsidiary company name			
Company registration number			
Address			
		Postcode	

Details of group administrator			
Name		Name	
Position		Position	
Telephone no		Telephone no	
Email		Email	

PLAN MANAGEMENT DETAILS

How many employees are being covered?			
What will employee cover be based on?			
All employees will be covered			
Specific grades of employees will be covered		Please state which grades will be covered	

Would you like to allocate plan cover according to the specific grades of employees indicated above?		
Yes		If yes, please use the membership template provided to indicate which employee group are allocated to which plan level using 'Group 1', 'Group 2' and 'Group 3' as applicable. You can select the plan cover level for each group in the 'Plan Cover' section.
No		If yes, please use the membership template provided to indicate which employee group are allocated to which plan level using 'Group 1', 'Group 2' and 'Group 3' as applicable. You can select the plan cover level for each group in the 'Plan Cover' section.

Note: The two group option is available for companies with over 10 employees. The three group option is available for companies with over 50 employees. Dependants must be on the same level of cover as the employee.

PLAN MANAGEMENT DETAILS (CONTINUED)

Whose cover will the employer pay for?			
Employee only		Employee & spouse	
Employee, spouse & all dependent children		Employee & all dependent children	

What date would you like the plan to start on? (dd/mm/yyyy) The start date must be the 1st of the month.	

Who should the invoice be sent to? Electronic invoices are default					
Recipient (choose 1 option):					
Employer only		Employer & broker		Broker only	
Format (choose 1 option):					
PDF		Excel			
Email address(es)					

MEMBER LITERATURE

All members will have access to a member portal where they can access plan literature. Member portal log in details will be provided in the member welcome email communication.

PLAN COVER

1. First, select your level of cover:	**Tick all that apply**		
Plan Level options	Group 1	Group 2 (If applicable)	Group 3 (If applicable)
Level 1			
Level 2			
Level 3			

2. Now, select a hospital/preferred provider network option:	**Note: You must select the same hospital network for both groups**		
Hospital/preferred provider network	Group 1	Group 2 (If applicable)	Group 3 (If applicable)
Cigna hospital/preferred provider network only			
Not restricted to Cigna hospital/preferred provider networks			

3. For Level 2 and Level 3, please select your Outpatient limit:	**Note: Level 1 provides full refund on Outpatient**		
Outpatient limit options	Group 1	Group 2 (If applicable)	Group 3 (If applicable)
Full refund			
£1,000			
£2,000			

4. Select your excess or co-payment amount

What excess amount (if any) has been selected?							
No excess		£100		£250		£500		£1,000

What co-payment amount (if any) has been selected?							
No co-payment		25% up to £100		25% up to £250		25% up to £500		25% up to £1,000

5. Finally, select your level of dental cover:
Where dental cover is selected, employees must all be on either a DentaCare or OralHealth plan with a minimum of 2 employees per Level.

Level of cover	Group 1		Group 2 (If applicable)		Group 3 (If applicable)	
No dental cover						
DentaCare Level 1						
DentaCare Level 2						
DentaCare Level 3						
DentaCare Level 4						
OralHealth Level 1						
OralHealth Level 2						
OralHealth Level 3						
OralHealth Level 4						
OralHealth Level 5						

UNDERWRITING OPTIONS

Are you currently insured with another provider?		Yes		No	
If you answered Yes, please complete the following questions:					
What are the company's current underwriting terms? (Please tick all that apply)					
Full medical underwriting		Moratorium		Medical history disregarded	
Please select current moratorium period: 2 years / 3 years / 5 years. Other (please state)					
If transferring to Cigna from another insurer, please remember to send us the transfer declaration form and up to date membership certificates from the previous insurer. The membership certificates must disclose any exclusions.					
If you answered No, please indicate your underwriting preference:					
Full medical underwriting - employees are required to complete an application form		Moratorium - employees are required to complete an application form to accept the Moratorium terms		Medical history disregarded - please complete the membership template provided	

TYPE OF BILLING

Please select preferred payment method. (Tick one option)					
Monthly direct debit		Quarterly by direct debit		Monthly BACS	
Quarterly By BACS		Annually by BACS			

INSTRUCTION TO YOUR BANK OR BUILDING SOCIETY TO PAY BY DIRECT DEBIT (IF APPLICABLE)

DIRECT Debit

Service user number - 715316	
To: The Manager of (Bank or Building Society name):	
Bank or Building Society address:	
	Postcode:

Name(s) of Account Holder(s):

Branch sort code:

Bank or Building Society Account Number:

Reference Number (for official use only):

Instruction to your Bank of Building Society

Please pay Cigna European Services (UK) Limited Direct Debits from the account detailed in this Instruction subject to the safeguards assured by the Direct Debit Guarantee. I understand that this Instruction may remain with Cigna European Services (UK) Limited and, if so, details will be passed electronically to my bank/building society.

Signature(s)

Date D D M M Y Y Y Y

THE DIRECT DEBIT GUARANTEE

- This Guarantee is offered by all banks and building societies that accept instructions to pay Direct Debits.
- If there are any changes to the amount, date or frequency of your Direct Debit Cigna European Services (UK) Limitied will notify you 10 working days in advance of your account being debited or as otherwise agreed. If you request Cigna European Services (UK) Limited to collect a payment, confirmation of the amount and date will be given to you at the time of the request.
- If an error is made in the payment of your Direct Debit, by Cigna European Services (UK) Limited or your bank or building society, you are entitled to a full and immediate refund of the amount paid from your bank or building society – If you receive a refund you are not entitled to, you must pay it back when Cigna European Services (UK) Limited asks you to.
- You can cancel a Direct Debit at any time by simply contacting your bank or building society. Written confirmation may be required. Please also notify us.

DECLARATION

I/We confirm that the above statements are true and complete. I/We hereby propose to Cigna Life Insurance Company of Europe S.A.-N.V. for a Cigna Health Flex Plan to start on the Commencement Date and agree to abide by the terms of that Policy and in particular to pay on the due dates the premiums required under the terms of the Policy.

Signature
(on behalf of proposing employer)

Write name in BLOCK CAPITALS

Position in the company:

Date D D M M Y Y Y Y

FOR AGENT'S USE ONLY

Please let us know where plan administrative documents should be sent			
Name			
Company name			
Company address			
		Postcode:	
Telephone no.		Email	
Agency reference			

Please let us know where plan commission details should be sent (if different from above)			
Name			
Company name			
Company address			
		Postcode:	
Telephone no.		Email	
Agency reference			

FOR INTERNAL USE ONLY

Commission payable		Salesperson	
Date received by Cigna			

Please give us a call on 01475 492138 if you need any help with your application.

Together, all the way.℠

Cigna®