Return completed form to:
Graduate Medical Education Office
920 Madison Ste. 447
Memphis, TN 38163

THE UNIVERSITY OF TENNESSEE
THE HEALTH SCIENCE CENTER
GRADUATE MEDICAL EDUCATION

GROUP HEALTH INSURANCE ENROLLMENT / CHANGE

CIGNA Health Care
2016-17

 NEW CONTRACT CHANGES TO EXISTING CONTRACT CANCEL COVERAGE
 CHANGE MY ADDRESS AS BELOW
 CHANGE COVERAGE TO: INDIVIDUAL EMP & SPOUSE EMP & DEPENDENT FAMILY
 CHANGE MY NAME AS BELOW ADD DEPENDENTS DELETE DEPENDENTS

EFFECTIVE DATE OF CHANGE____

REASON FOR CHANGE____

LAST NAME_____________________________FIRST NAME________________________MI______SEX____________

SOCIAL SECURITY NO.____________________DATE OF BIRTH_______________PHONE NO.____________________

MAILING ADDRESS_____________________________CITY__________________STATE____________ZIP__________

DEPENDENT COVERAGE: YES_______ NO________

	LAST NAME	FIRST NAME	MI	DATE OF BIRTH	SOCIAL SECURITY#	GENDER
SPOUSE						
CHILD						
CHILD						
CHILD						
CHILD						
CHILD						

I ACKNOWLEDGE THE ABOVE REQUEST FOR ENROLLMENT/CHANGE IN MY HEALTH INSURANCE COVERAGE AND AUTHORIZE THE APPROPRIATE MONTHLY DEDUCTION FROM MY EARNINGS FOR THE TYPE OF COVERAGE SELECTED.

2016-17 Employee Portion Insurance Rates

 IND ($100.00) EMP & SPOUSE ($200.00) EMP & DEP ($175.00) FAMILY ($275.00)

____ _____________________________
SIGNATURE DATE

UTGME OFFICE USE ONLY

_________________________________ _______________________________ _________________________
DATE RECEIVED EFFECTIVE DATE LOCATION