

CIGNA Dental Coverage Enrollment Form

Personal Plans

Complete the enrollment form in ink and retain a copy of the completed form for your records.

1. APPLICANT INFORMATION

Participant name: _____ Social Security number: _____

Daytime telephone: (_____) _____ Gender: Male Female Birth date: ____/____/____

Home address: _____

City: _____ State: _____ ZIP Code: _____

Employer name: _____ Account number: _____

Employer Identification Number (EIN): _____ Work telephone: (_____) _____

Work address: _____

City: _____ State: _____ ZIP Code: _____

Employer signature: _____ Date: ____/____/____

2. SELECT A PLAN OPTION

- Premier Dental Care Plan Choice Dental Care Plan
 Guided Dental HMO Plan (Available in selected areas only. If selecting this plan, indicate a dental office number below for each covered dependent.)

3. LIST ALL FAMILY MEMBERS TO BE COVERED

Last name	First name	Social Security number	Relationship	Birth date	Male/female	Dental facility number Guided Dental HMO Plan
		_____	Self	_____	_____	

To the best of my knowledge and belief, each of the statements and answers supplied in this form is complete and true, and they constitute the sole basis for, and are the inducement for, the issuance of any insurance.

Applicant signature: _____ Date: ____/____/____

GUIDESTONE USE ONLY

Processed by: _____ Date: ____/____/____ Coverage effective date: ____/____/____

Return this Authorization to: GuideStone Financial Resources
Insurance Operations – Personal Plans
2401 Cedar Springs Road
Dallas, TX 75201-1498

You may also fax this form to: 214-720-4676

