Arizona 2025 Business Enrollment Form

Instructions

The attached forms should be completed with the assistance of your authorized Broker or Enrollment Guide prior to your effective date. Please complete all necessary forms in their entirety. Please print in ink or type your responses and ensure that all areas requiring a signature and date are complete.

Required Documents

Please complete the following documents to enroll.

Arizona 2025 Business Enrollment Form

Arizona Employee Enrollment application(s)

One application should be completed for each enrolling employee or COBRA/Continuation of benefits recipient.

Employee waiver form(s)

One form is needed for each employee waiving or refusing coverage.

Business Entity Document

Required for all enrolling groups to verify they're eligible to conduct business in the state of Arizona.

Payroll verification through appropriate tax documentation

A1-QRT is required for all enrolling groups, unless there are seven (7) or more eligible enrolling employees. Documents submitted must include all enrolling employees. Additional tax documentation may be required based on group type (see Underwriting Guidelines for additional information).

ACH Authorization Form

This is optional but highly encouraged to expedite member ID card delivery. ACH payments can be setup for automatic deduction on the first of every month or can be uploaded solely for an automatic first payment.

If the **group wishes to pay the first premium via check**, they must wait for approval and the first bill generation and delivery.
The **first premium check** should be **mailed** along with the bill stub and can be overnighted to the following address:

CIGNA Overnight Premium Address
Attn Cigna Healthcare-551
6125 Lakeview Road Suite 800
Charlotte, NC 28269

Section A: Business information

Business name	Doing business as (if applicable)		
Business address (Not P.O. Box)			
City	State	ZIP code	County
Mailing Address (if different from address above)			
Federal Tax ID number	SIC code (optional)	Nature of business	

Business classification

☐ S Corp ☐ C Corp ☐ Non-Profit ☐ Partnership ☐ LLC ☐ LLP ☐ Other (please explain):

Was this business established within the last year?

☐ No ☐ Yes If yes, date business was established (mm/dd/yyyy):

Section A.1: Business contacts (please include the person(s) responsible for managing the business' account)

First name	Last name		Job title
Email	Phone	Ext.	Fax (optional)

Is this person also the billing contact? ☐ No ☐ Yes

Is their mailing address different then the business's address? ☐ No ☐ Yes → If yes, please complete the information below:

Address		
City	State	ZIP code

Additional business contact (optional)

First name	Last name		Job title
Email	Phone	Ext.	Fax (optional)

Is this person also the billing contact? ☐ No ☐ Yes

Is their mailing address different then the business's address? ☐ No ☐ Yes → If yes, please complete the information below:

Address		
City	State	ZIP code

Section A.2: Business affiliates

If the business has any affiliates that qualify as a single employer under subsection (b), (c), (m) or (o) of the Internal Revenue Code, Section 414, please complete the information below for each affiliated entity.

Legal name	Location	Tax Identification Number (TIN)	Number of full time employees	Employees enrolling

Section A.3: Agent/producer/broker certification (to be completed by the appointed agent/broker)

1. I am not aware of any additional information not contained within this application that may have bearing on this group or any member's eligibility.
2. I have not completed any of the information contained in the application except with the permission of the applicant and as noted by my initials and date on the application.
3. I have not signed any of the applications for an employer representative or individual employee's application. If after submission of this application, I request any additions or changes to any information, I will do so only with the written consent of the applicant, and I authorize Cigna Healthcare Small Group to attribute such additions or changes to me.
4. I have advised the employer that a failure to provide complete and accurate information may result in a loss of coverage retroactive to the effective date of coverage and that coverage shall not be effective until Cigna Healthcare Small Group reviews and approves the application and the employer receives a written notice from Cigna Healthcare Small Group.
5. I am the appointed agent/broker and am receiving commissions for the submission of this client. No portion of my commission payments from Cigna Healthcare Small Group shall be paid to an agent/broker/producer not appointed/approved by Cigna Healthcare Small Group.
6. I have advised the client not to terminate any existing coverage until receiving written notification from Cigna Healthcare Small Group that the coverage being applied for by this application is accepted.

Writing payable/sub-agent/producer/broker		Second writing payable/sub-agent/producer/broker	
First name	Last name	First name	Last name
Broker ID		Broker ID	
NPN (optional)		NPN (optional)	
Phone		Phone	
Email		Email	
Commission percentage (if splitting with a second broker):		Commission percentage (if splitting with a second broker):	
Signature X	Date (mm/dd/yyyy)	Signature X	Date (mm/dd/yyyy)

Section A.4: Prior carrier coverage (required)

If this plan is a total replacement of any existing group plans, please list the carrier and relevant information below:

Prior carrier name	Total replacement? (Y/N)	Start date (mm/dd/yyyy)	End date (mm/dd/yyyy)

Section B: Eligibility and enrollment[1]

Preferred effective date of coverage (mm/dd/yyyy)? Must be 1st or 15th of a future month.

Coverage offered to all eligible employees working an average of:

(●) 20+ hrs ( ) 30+ hrs

Total number of full-time equivalent (FTE) employees[2] over the previous calendar year? (including employed owners/officers and part-time employees; excluding COBRA)

Total number of eligible employees?

How many current employees will be enrolling? (excluding COBRA members)

How many eligible employees will be submitting valid waivers? At least 50% of all eligible employees must participate in the policy. Refer to Underwriting Guidelines for more detail.

Did your business have 20 or more total employees during at least 50% of the working days in the previous calendar year?[3]
(If yes, your business is subject to COBRA and Arizona State Continuation. If no, your business is subject to Arizona State Continuation of Coverage.) ☐ No ☐ Yes

Will (or did) your business have at least 20 full-time and part-time employees for at least 20 weeks in the current or last calendar year?[4] ☐ No ☐ Yes

[1] Cigna Healthcare Small Group requires certain forms of proof to establish eligibility. Please contact us at 1-877-991-2617 for our details regarding eligibility categories and required forms of proof. At least one (1) eligible, active, full-time employee must be enrolled (excluding officers/owners). Cigna Healthcare Small Group reserves the right to request additional documentation to confirm number of hours worked and other relevant information when verifying group size/eligibility for participation.

[2] The FTE employee counting method in 26 U.S.C. § 4980H(c)(2) must be utilized to determine group size for medical coverage. For more information, refer to the Underwriting Guidelines.

[3] Use the FTE employee counting method described above.

[4] Include all full-time employees, part-time employees, seasonal employees, temporary employees, union workers, owners, partners and officers. Exclude self-employed persons, independent contractors (1099), directors and leased employees. Unlike the FTE counting method above, here, each included employee counts as one.

Section C: Employee medical coverage selection

Complete the following section to select plan details. If you have any questions, please contact us at CignaGroup.NewBusiness.ext@wipro.com.

Section C.1: Plan Information

Select waiting period for new employees in this class:

- ☐ None
- ☐ First of the month following Date of Hire
- ☐ First of the month following one month (30 days) from Date of Hire
- ☐ First of the month following two months (60 days) from Date of Hire
- ☐ 30 days from Date of Hire
- ☐ 60 days from Date of Hire
- ☐ 90 days from Date of Hire

Choose the employer medical premium contribution amount for each month for employees:

_____ % or $ _____

Note: Employers must contribute at least 50% of the employee premium.

Choose the employer medical premium contribution amount for each month for employees' dependents:

_____ % or $ _____ ☐ No contribution

Note: This section should only be filled out if you would like to contribute a different amount towards employee's dependents. Use same contribution type (% or $).

Section C.2: Plan Selections - All plans include pediatric dental coverage.

Select up to 3 plans to offer this class (visit CignaHealthcare/small-group-health-insurance-plans for full plan details):

- ☐ Cigna Healthcare Small Group LocalPlus® Bronze $6000 HSA
- ☐ Cigna Healthcare Small Group LocalPlus® Bronze $7500
- ☐ Cigna Healthcare Small Group LocalPlus® Bronze $7900 HSA
- ☐ Cigna Healthcare Small Group LocalPlus® Silver $3550
- ☐ Cigna Healthcare Small Group LocalPlus® Silver $4250
- ☐ Cigna Healthcare Small Group LocalPlus® Silver $5000
- ☐ Cigna Healthcare Small Group LocalPlus® Gold $1250
- ☐ Cigna Healthcare Small Group LocalPlus® Gold $1800
- ☐ Cigna Healthcare Small Group LocalPlus® Gold $2750
- ☐ Cigna Healthcare Small Group LocalPlus® Platinum $750

- ☐ Cigna Healthcare Small Group Open Access Plus Bronze $6000 HSA
- ☐ Cigna Healthcare Small Group Open Access Plus Bronze $7500
- ☐ Cigna Healthcare Small Group Open Access Plus Bronze $7900 HSA
- ☐ Cigna Healthcare Small Group Open Access Plus Silver $3550
- ☐ Cigna Healthcare Small Group Open Access Plus Silver $4250
- ☐ Cigna Healthcare Small Group Open Access Plus Silver $5000
- ☐ Cigna Healthcare Small Group Open Access Plus Gold $1250
- ☐ Cigna Healthcare Small Group Open Access Plus Gold $1800
- ☐ Cigna Healthcare Small Group Open Access Plus Gold $2750
- ☐ Cigna Healthcare Small Group Open Access Plus Platinum $750

Deductibles and out-of-pocket accumulation period are on a...	☐ Calendar year	☐ Contract year basis
Would you like premiums to be composite rated or age-rated?	☐ Composite Rated	☐ Age Rated
Do you wish to offer coverage for Domestic Partners?	☐ No	☐ Yes

Section D: General agreement

Please read this section carefully before signing the application:

We apply to obtain the coverage designated herein. To the best of our knowledge and belief, all information on this application is true and complete, and Cigna **Healthcare Small Group** may rely on this application in deciding whether to provide coverage. If the application is not complete, **Cigna Healthcare Small Group** reserves the right to reject it and notify us in writing. We understand and agree that no coverage will be effective before the date determined by Cigna Healthcare Small Group, and that such coverage will be effective only if we have paid our first month's premium and this application is accepted. We further understand and agree that we should keep prior coverage in force until notified of acceptance in writing vy Cigna Healthcare Small Group and that no agent has the right to accept this application or bind coverage. If this application is accepted, it becomes a part of our contract with **Cigna Healthcare Small Group**.

The Brokers named on this application are hereby authorized to process any enrollment transactions for the company's Cigna Healthcare Small Group coverage upon direction from the authorized group representative (including, but not limited to, member enrollment, member terminations, member address changes, group contact changes, group address changes, plan renewal changes, and group contract terminations). This authorization shall be effective immediately and we agree that the company will be bound by the actions performed by the herein-named Broker pursuant to the signature below. Additionally, we acknowledge that we must notify **Cigna Healthcare Small Group** in writing to void this agreement in the event of a change in the company's Broker of Record.

Business administrator signature Sign here X.....	Printed name and title	Date (mm/dd/yyyy)
Accepted by Cigna Healthcare Small Group authorized representative	Printed name	Date (mm/dd/yyyy)
I am authorized to sign on the company represented in this surveys behalf		Yes ☐ No ☐