Town of Plaistow
145 Main Street
Plaistow, NH 03865
TEL: 603-382-5200
FAX: 603-382-7183

2024 Employee Benefit Information

Pay Day & Timesheets
Pay day is Thursday of each week. Timesheets are to be submitted to the Finance Office no later than 10AM Monday, unless otherwise specified, and signed by your supervisor. The work week begins on Sunday and ends on Saturday each week.

Beginning the first day of the month, following thirty (30) days of employment, the Town provides the following insurance benefits to Full-Time Employees:

HealthTrust Basic Life Insurance policy with a 1 ½ times salary benefit.

HealthTrust Short-Term and Long-Term Disability Insurance

(HealthTrust Basic Life, Short-Term and Long-Term Disability Insurance are Town paid benefits that the employee does not contribute to.)

Health & Dental Plan coverage: *(Optional)*

Company Monthly Rates:	**Single**	**2-Person**	**Family**
A. **HealthTrust Lumenos**	$1016.38	$2032.77	$2744.24
B. **HealthTrust Access Blue**	$1247.04	$2494.08	$3367.00
C. **Delta Dental Plan**	$ 50.49	$ 94.54	$ 174.47

HealthTrust Lumenos, Access Blue and Delta Dental plans are offered to Non-Union personnel.

D. **Plaistow Police Teamster's Union:** Allegiant Care *(Health & Dental)*	$ 974.00	$2047.00	$2598.00
E. **Plaistow Non-Police Union:** Allegiant Care *(Health & Dental)*	$ 974.00	$2047.00	$2598.00

The Town pays 85% of all the above Health/Dental coverage and the employee is responsible for 15% through payroll deduction. You may waive health insurance

coverage with a buyout option as described in the personnel plan and collective bargaining agreements. HealthTrust rates are effective January 1st annually. Allegiant Care rates are effective July 1st annually.

New Hampshire Retirement System (NHRS)

NH Retirement Membership is a condition of employment and NHRS contributions are mandatory for full-time employees for an individual who meets the requirements as indicated at NHRS Membership Eligibility for Groups I & II as indicated below. https://www.nhrs.org/employers/employer-resources/hr-personnel-resources/membership-eligibility.

Group I (Employees and Teachers)
Group II (Permanent Police and Firefighter)

You may review Member Benefits, FAQ's and Governance of the retirement system at www.nhrs.org.

Deductions:
Regular Employees have 7% deducted from pay and the Municipality contributes 13.85%. of earnings.
Police Department Employees have 11.55% deducted from pay and the Municipality contributes 31.28% of earnings.
Fire Department Employees have 11.8% deducted from pay and the Municipality contributes 30.35% of earnings.

NHRS enrollment starts on day one of employment, with deductions starting with the first paycheck.

Regular Employees are guided by the Personnel Plan and Teamsters by their contract. Copies of the appropriate document are provided on or by your first day of work.

The Town also offers **voluntary** participation in the following benefits:

457 Retirement Plan with Variable Annuity Life Insurance Company
The Sales Representative can be reached at 800-448-2542. Group #63515.

AFLAC Accident Insurance
The Sales Representative John Amero can be reached at 978-269-4338.

HealthTrust

LIFE, LONG-TERM DISABILITY (LTD), AND/OR SHORT-TERM DISABILITY (STD) APPLICATION AND CHANGE FORM

WELCOME TO HEALTHTRUST

Use this form to change your beneficiary(ies) as well as to enroll in or change your disability and/or life insurance coverage. If you only need to change your mailing address, do not complete this form; instead, call HealthTrust's Enrollee Services Department at 800.527.5001 and notify your employer.

BE SURE TO FILL OUT EACH SECTION COMPLETELY. Failure to complete each section in full could delay the start of coverage.

HOW TO COMPLETE THIS FORM

Remove this cover sheet before you begin.

STEP 1	**EMPLOYEE INFORMATION** Complete this section with your personal information, using your full legal name. Select the type of HealthTrust-sponsored life and/or disability coverage you are requesting. Please limit your selection to only those coverages offered by your employer and for which you are eligible. Some life and disability coverages may require evidence of insurability. You will not be eligible for any amount greater than the evidence of insurability requirement if you do not submit an *Evidence of Insurability* form; this form may be obtained from your employer or HealthTrust. You will be added for an amount greater than the evidence of insurability requirement once approved. For more information, refer to your certificate of coverage.
STEP 2	**REASON FOR COMPLETING APPLICATION** Use this section to indicate the reason(s) for completing form.
STEP 3	**BENEFICIARY INFORMATION** Please name your beneficiary(ies) for your life and/or disability coverages. If you wish to name a different beneficiary(ies) for your life, long-term disability (LTD), and/or short-term disability (STD) coverages, attach a separate piece of paper containing all necessary information. Otherwise, your beneficiary(ies) will be the same for all coverages. You may name more than one beneficiary. If you specify benefit percentages, the total must equal 100 percent. If you do not specify benefit percentages, benefits will be paid in equal shares. If you do not name a beneficiary(ies) – or if neither your primary nor contingent beneficiary(ies) survive you – benefits will be paid in order of survivorship shown in your certificate of coverage. Your primary beneficiary(ies) are the person(s) you name to receive benefits. Your contingent beneficiary(ies) are the person(s) you name to receive benefits if your primary beneficiary(ies) do not survive you.
STEP 4	**EMPLOYEE SIGNATURE** Sign and date this form; return completed form to your employer (retain the pink copy for your records).
STEP 5	**EMPLOYER USE ONLY** Employer must review this form and verify that steps 1-4 are completed. Employer must complete this section and forward to HealthTrust for processing at: PO Box 617, Concord, NH 03302, or through the Secure Message Center in your Secure Member Portal (SMP) account, email enrolleeservices@healthtrustnh.org or fax 603.226.2988

LIFE, LONG-TERM DISABILITY (LTD), AND/OR SHORT-TERM DISABILITY (STD) APPLICATION AND CHANGE FORM

EMPLOYEE INFORMATION

STEP 1

Last Name	First Name	MI
Social Security #	Date of Birth	Gender ☐ Male ☐ Female
Mailing Address		Telephone
City	State	Zip
Employer Name		

Marital Status

- ☐ Single
- ☐ Married
- ☐ Widowed
- ☐ Divorced/Legally Separated

TYPE OF COVERAGE REQUESTED (check)

Life Coverage

- ☐ Basic Life
- ☐ Supplemental Life
- ☐ Dependent Life

Disability Coverage

- ☐ Long-Term Disability
- ☐ Short-Term Disability

STEP 2

REASON FOR COMPLETING FORM

- ☐ New Enrollee
- ☐ Benefit Change
- ☐ Part Time to Full Time
- ☐ Other _____
- ☐ Name Change
- ☐ Change in Beneficiary ONLY

Actual Date of Event _____

BENEFICIARY INFORMATION

STEP 3

Name of Beneficiary	Date of Birth	Relation to Employee	Social Security #	Benefit Percentage
Primary Beneficiary				%
Primary Beneficiary				%
Primary Beneficiary				%
				Total: 100%
Contingent Beneficiary				%
Contingent Beneficiary				%
				Total: 100%

ENROLLEE SIGNATURE

STEP 4

I hereby authorize HealthTrust and my employer to institute the action(s) indicated on this form. If my employer requires a contribution for this coverage, this authorizes the appropriate payroll deductions. I understand that the ef fective date and termination date of my membership will be determined by HealthTrust and my employer in accordance with the plan rules. I understand that I must sign this form for claims to be processed and beneficiary designation(s) to be made valid. By signing this application, I at test to the accuracy and truthfulness and will provide documentation to HealthTrust upon request.

Enrollee Signature_____ Date ___/___/___

EMPLOYER USE ONLY

STEP 5

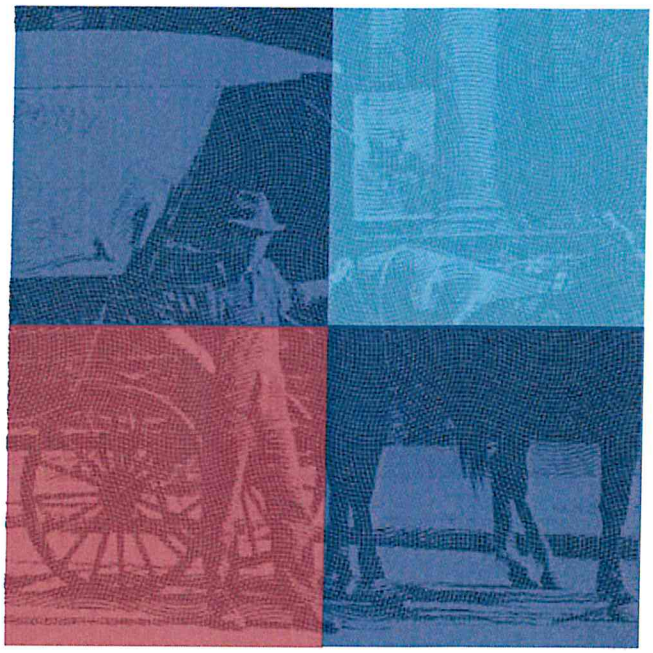
Date of Hire	Date of Rehire	Billing Group Name	
Full-Time Number of Hours	Part-Time Number of Hours	Base Annual Salary	Employee Job Title

Basic Life Coverage	Additional Life Coverage	Long-Term Disability Coverage	Short-Term Disability Coverage
Class Number	☐ Supplemental	Class Number	Class Number
Effective Date of Coverage	☐ Dependent	Effective Date of Coverage	Effective Date of Coverage
Basic Life Benefit Amount		Benefit Administrator Signature/Stamp	Date
Supplemental Life Benefit Amount			

HealthTrust

Allegiant Care
HEALTH BENEFITS FOR TEAMSTERS

Health and Welfare Benefit Summary for Town of Plaistow



An Outstanding Partnership...

Allegiant Care is committed to partnering with its members and their employers to provide **HIGH QUALITY**, **COMPREHENSIVE**, and **COST-EFFECTIVE** healthcare benefits for those members and their families to improve and maintain their quality of life.

As fellow Teamsters, the staff at Allegiant Care identifies with members' needs and goes above and beyond to provide superior service and devoted customer care, establishing **PEACE OF MIND**, **SECURITY** and the **LOYALTY** they have come to expect from Teamsters.

CONTENTS

...Serving members through high-quality healthcare benefits

About Allegiant Care

Allegiant Care is a nonprofit health and welfare benefits fund dedicated to delivering the highest quality healthcare for Teamsters at the best price. For over 50 years, Allegiant Care (formerly Northern New England Benefit Trust) has provided members with comprehensive, cost-effective benefits with the goals of improving members' quality of life and providing peace of mind.

Allegiant Care is single-minded in its commitment to its members. Allegiant Care is "Teamsters taking care of Teamsters." Allegiant Care representatives are there to help members navigate the often-confusing healthcare maze. They are committed to working with members to resolve issues promptly. With one phone call, members can get answers about medical, prescription, dental, vision, life, disability and retiree medical benefits.

With a proud history as a trusted leader in healthcare for over half a century, Allegiant Care will continue to advocate on behalf of Teamster members and their families.

Summary of Medical Coverage
CIGNA

This document is for summary purposes only. Complete details will be provided in the Summary Plan Description which will be mailed to members upon initial eligibility.

Type of Care	OAPA8 Cost to Member (Network Provider)
Plan Information	
Annual Deductible (In-Network Provider) Annual Deductible (Out-of-Network Provider)	No deductible $250 Individual/$500 Family
Out of Network Coinsurance	20% coinsurance after deductible
Inpatient/Day Surgery Out-of-Pocket Maximum Medical Copays/ER/Urgent Care Out-of-Pocket Maximum Prescription Copay Out-of-Pocket Maximum	$1,000 Individual/$2,000 Family $2,100 Individual/$4,200 Family $2,500 Individual/$5,000 Family
Office Visits	
Preventive Care	No charge (Not covered out-of-network)
PCP Visit (other than preventive)	$15 copay/visit
Specialist Visit	$25 copay/visit
Chiropractor	$25 copay/visit, up to 34 visits/year
Prenatal Care	PCP or Specialist copay to confirm pregnancy; no copay for subsequent visits
Outpatient Care	
Outpatient Surgical Procedure	10% coinsurance
CAT/PET/MRI scans at outpatient facility	$100 scan copay + 10% coinsurance
Routine Lab/X-ray	No charge (Lab not covered out-of-network)
Inpatient Care	
Hospital Stay	10% coinsurance
Skilled Nursing Facility	10% coinsurance
Emergency Care	
Emergency Room	$100 copay/visit (waived if admitted)
Ambulance Transportation (Medically Necessary)	No charge
Urgent Care	$25 copay/visit
Continuing Care	
Outpatient Therapy (Physical, Occupational, Cardiac, Speech)	$25 copay/visit
Home Health Care	No Charge
Hospice Care	Outpatient-No charge; Inpatient-10% coinsurance
Durable Medical Equipment	No charge upon approval
Pre-Authorization Required for some services including but not limited to the following: Imaging, Inpatient, Behavioral Health, Substance Abuse, Outpatient Therapy, Skilled nursing care, Home/Hospice care, Durable Medical Equipment	

Summary of Prescription Coverage

The prescription drug benefit program is currently administered through Allegiant Rx for retail and OptumRx® for mail order prescriptions. Use of generic medications is preferred whenever possible, as there is a higher cost to the member for brand name medications. For retail prescriptions there is an additional cost if a brand name drug is prescribed when a generic drug is available.

Retail Purchases (up to 30-day supply)

Retail benefits are available at all major pharmacies (except Wal-Mart, Walgreens or Sam's Club). Members should present their Allegiant Rx/ OptumRx Pharmacy card and ask the pharmacist to confirm participation before filling a prescription. Members may also visit www.myallegiantrx.com to locate an in-network pharmacy. **Retail purchases are limited to a 30-day supply.**

Mail Order Purchases (maintenance medications up to 90-day supply)

Mail-order prescriptions are processed through Allegiant Rx/ OptumRx. OptumRx will dispense up to a 90-day supply of a drug, subject to the prescription written by the physician and to the Allegiant Rx Pharmacy Limitations and Exclusions. OptumRx will dispense a brand name drug only if no generic drug equivalent is available.

Benefit	Cost to Member (Network Providers)	
	Retail (Up to 30-day supply)	Mail Order (Up to 90-day supply)
Annual Deductible	$0 Individual/$0 Family	$0 Individual / $0 Family
Prescription out-of-pocket Maximum	$2,500 Individual/$5,000 Family (combined retail and mail order)	
Types of Prescriptions		
Generic	Lower of cost or $15 copay	Lower of cost or $15 copay
Brand Name	$25 copay	$25 copay (only available when generic is not available)
Brand Name if Generic is Available	$25 Brand copay + difference between brand and generic	Not available
Specialty Drugs Limited to 30-day supply	Not available through retail	$25 copay Available through OptumRx
Diabetic Lancets/Test Strips	Not available through retail	$25 copay

Summary of Dental Coverage

The Allegiant Care dental plan has no network restrictions. Members may use the provider of their choice, and providers have the ability to submit claims electronically for payment.

The plan operates on a fee schedule (attached), whereby the plan will pay up to a designated amount per dental code. This amount is based on average claim charges from the previous calendar year. Members are encouraged to present the fee schedule to their dental provider. A pre-treatment estimate is recommended for any care that will result in a claim exceeding $250.00.

Type of Care	Coverage Amounts	Member Responsibility
Deductible	Basic and Major Care (Does not apply to Preventative)	$25 Individual / $50 Family
Annual Maximum	No all-inclusive maximum $1,200 Periodontic / $1,200 Prosthodontic per individual	
Type of Care	**Coverage Amounts**	**Member Responsibility**
Preventive Care (oral exam, X-rays, routine cleaning, fluoride treatments, sealants)	The Fee Schedule amount is paid, which reflects 100% of average provider charges. (Age and Frequency limitations may apply)	Balance that exceeds the Fee Schedule amount paid. Not subject to the annual deductible.
Basic Care (fillings, routine extractions, root planning/ scaling, root canal)	The Fee Schedule amount is paid, which reflects 80% of average provider charges.	Balance that exceeds the Fee Schedule amount paid.
Major Care (crowns, bridges dentures)	The Fee Schedule amount is paid, which reflects 50% of average provider charges.	Balance that exceeds the Fee. Schedule amount paid.
Orthodontia*	Plan pays 75% of provider charges up to $1,500 lifetime max.	Balance that exceeds the amount paid by the plan.

** Benefit available after six consecutive months of dental coverage under the plan.*

Following are examples of how the Dental Fee Schedule works.

- ***Example 1:*** If the Fee Schedule indicates the Plan will pay $100.00 for a service and your provider bills $95.00, the Plan will pay $95.00 and you will owe nothing.
- ***Example 2:*** If the Fee Schedule indicates the Plan will pay $100.00 for a service and your provider bills $120.00, the plan will pay $100.00 and you will be responsible for the remaining $20.00.

Summary of Vision Coverage
Davis Vision

The plan uses the Davis Vision provider network. If there is not a Davis Vision Provider available in the member's area, Davis Vision will locate a provider and assign temporary network status to accommodate the member's service needs.

If the member chooses to use a provider who is not part of the Davis Vision Network, they may file an individual claim and receive up to $45 reimbursement for the examination and up to $55 reimbursement for one pair of eyeglasses or contact lenses.

To find a participating provider, contact Davis Vision at 1-800-999-5431 or visit www.davisvision.com.

NOTE: All parts of the vision benefit (*i.e.,* exam, lenses and glasses) must be submitted with a single date of service through the same provider for the claim to be approved.

Family Members	Service	Frequency
Member and Spouse	One Free routine eye examination (including dilation as professionally indicated)	Once every 24 months
	One Free pair of glasses including Davis Vision frame	
	Second pair of glasses available for $25 co-pay + discounted rates for frame/lens optional items.	
Adult Dependents (ages 19 26)	One Free routine eye examination (including dilation as professionally indicated)	Once every 24 months
	One Free pair of glasses including Davis Vision frame	
Dependent Children (before 19th birthday)	One Free routine eye examination (including dilation as professionally indicated)	Once every 12 months
	One Free pair of glasses including Davis Vision frame	

Contact Lenses

There are two options for purchasing contact lenses:

Plan Contact Lenses with $20 copay: contact lenses manufactured and/or distributed by Davis Vision and include standard, soft, daily-wear, disposable or planned replacement contact lenses. (Fitting and follow-up are included.)

Non-Plan Contact Lenses with $105 credit: The credit will be applied toward any contact lenses not distributed by Davis Vision. (Fitting and follow-up are not included.)

If you are purchasing contact lenses and eyeglasses, Davis Vision will process your contact lens claim as your "first" pair ($20 copay applies) and your eyeglasses as your second pair ($25 copay applies).

Supplemental Benefits Overview

	Hearing Benefit	Health Club Benefit	Massage Benefit
Qualifying Members	• Members or dependents over the age of 19	• Members and covered spouses	• Members and covered spouses
Benefit Coverage	• Hearing evaluations • Hearing aid purchase • Member may use any provider • Extra discount for using EPIC Hearing network provider	• $100.00 payable after a six-month period with at least an average 3x/wk participation	• $30.00 per massage
Benefits Limitations	• Benefits are paid at 75% of the total cost • Total reimbursement limit $1,500.00 • Payable once every 5 years	• Must be a covered member or covered spouse during the entire six-month period • Must engage in physical activity an average of three times per week during the 6-month period	• $1,000 per calendar year per eligible member or spouse
Filing Claims	• Pay provider in full • Submit Allegiant Care reimbursement form and attach all necessary receipts. • Receive reimbursement	• Pay membership in full • Submit Allegiant Care reimbursement form (completed and signed by health club representative) and receipt for payment • Receive reimbursement	• Pay licensed massage therapist in full • Submit Allegiant Care reimbursement form (completed and signed by massage therapist) and receipt for payment • Receive Reimbursement

Life Insurance Overview

Allegiant Care offers a life insurance policy to all active members. Members are required to provide beneficiary information so that the benefit may be paid in the event of the death of a member or dependent.

Coverage Type	Benefit Paid
Active Member (through age 69)	$25,000
Spouse	$5,000
Dependent Child	$2,500
Accidental Death/Dismemberment Active Member (through age 69)	$25,000

If a member continues to actively work after age 69, the Life Insurance and Accidental Death/Dismemberment benefits will be reduced as follows:

On the Date the Member...	Benefit is Reduced to...
Becomes age 70	$12,500
Becomes age 75	$7,500

Legal Defense (Duty-Related Incidents)

Law Enforcement Members Only

Allegiant Care will pay a covered member's legal fees for the following matters arising directly from a "duty related incident" as defined below.

1. Defense of criminal charges, including all hearings or appearances before any court of Federal, State or local government, in which the covered member is the defendant.
2. Advice, consultation and preparation for a grand jury investigation hearing involving a covered member.
3. Defense of all civil lawsuits.
4. Defense of administrative proceedings arising from incidents involving a member of the public.

Schedule of Benefits

Benefit	Participating Attorney	Non-Participating Attorney
Defense of criminal charges/civil lawsuit • Trial Preparation • Trial	Paid in Full	• $10,000 maximum • Up to $800/day maximum $10,000
Advice, consultation & preparation for Grand Jury hearings	Paid in Full	Up to $3,000
Defense of employment disciplinary proceedings involving "official misconduct" and non-duty related Personnel matters	Paid in Full	Up to $10,000

Reimbursable costs are paid in full. However, the limitation for investigative fees in connection with the above covered matters is $1,000, and the limitation for expert witness fees is $3,500.

Retiree Qualifications

For many years, Allegiant Care has provided subsidized medical and prescription benefits for long-term member/participants and their spouses who retire before reaching Medicare age. While the Board of Trustees may modify the current benefit and eligibility rules or even eliminate this benefit, the following describes the benefit and some of the most important rules.

The Benefit

If a member meets the general eligibility requirements, the member, once retired, is eligible for up to eight (8) years of subsidized medical and prescription benefits. The member's spouse also will be eligible for up to eight (8) years of subsidized medical and prescription benefits provided the spouse accesses retiree coverage at the same time as the member.

The amount of the subsidy is based on the age of the member and spouse when the member accesses the subsidized coverage, as shown in the following schedule:

Member		Spouse	
Age 57	50% subsidy	Age 59 or less	50% subsidy
Age 60	70% subsidy	Age 60	70% subsidy
Age 62	100% subsidy	Age 62	100% subsidy

Note: the spouse's subsidy percentage cannot be greater than the member's subsidy, regardless of the spouse's age.

General Eligibility Rules

- The member must be at least age 57 and must have at least thirteen (13) continuous years of medical coverage with Allegiant Care immediately prior to retiring OR at least twenty (20) years of coverage with Allegiant Care.
- In determining years of coverage, a member, who has years of employment with the member's employer when the employer first becomes a contributor to Allegiant Care, will be credited with two (2) years of prior service for each year the member is covered by Allegiant Care.
- If it is likely that a member must rely on the thirteen (13) years of continuous coverage to qualify for retiree coverage, it is critical that a member not allow a lapse in coverage even for a short duration. The member should consider taking advantage of any available pay-in options or COBRA coverage to bridge any lapses in employer-sponsored coverage.
- The member must be a member of the Teamsters Union for all the time the member is a participant with Allegiant Care.

Important Notes:

- **The member must be a Teamster member.** Being a "fair share payer" is not sufficient.
- A member, including a retired member, will only be eligible if the member's employer (or former employer in the case of a retiree) remains a contributor to Allegiant Care and if the employer remains in operation.

Members and retirees from groups that decertify or that opt for insurance coverage from entities other than Allegiant Care do not remain eligible for retiree coverage.

Allegiant Care
HEALTH BENEFITS FOR TEAMSTERS

P.O. Box 4604 • 800.258.9732
51 Goffstown Road • 603.669.4771
Manchester, NH 03108 • f 603.666.4477

Enrollment Form

Instructions:

1. **Complete, sign, and return this enrollment form along with any required supporting documentation as soon as possible to avoid delays in claims processing.**
2. **Be sure to provide social security numbers for members and all covered dependent(s).**
3. **If you and/or any dependent(s) had prior coverage that will be terminating, you must submit proof of cancellation or a HIPAA Notice indicating the date coverage ended.**

SELECT ALL THAT APPLY:

❒ New Member ❒ Add New Dependent ❒ Change Marital Status ❒ Change Name
❒ Reinstating ❒ Cobra Election ❒ Plan Change ❒ Other Insurance

Type of Dependent	Required Supporting Documentation
Spouse	❒ Copy of state-issued Marriage Certificate
Ex-Spouse	❒ Copy of Divorce Decree showing your responsibility for the ex-spouse's coverage (some plans do not provide for ex-spouse coverage)
Natural Child	❒ Copy of state-issued Birth Certificate (a birth notice is acceptable for newborns for the first 60 days; however, a state-issued Birth Certificate must be provided for continued coverage beyond 60 days)
Adopted Child	❒ Copy of state-issued Birth Certificate; AND ❒ Copy of Adoption Certificate/Documents
Step Child	❒ Copy of state-issued Birth Certificate; AND ❒ Copy of any applicable Divorce Decree or Support Order showing responsibility for the child's insurance coverage
Foster Child or Legal Dependent	❒ Copy of state-issued Birth Certificate: AND ❒ Copy of Legal Guardianship Documents

Once enrollment form and all supporting documentation have been submitted, please allow 7-10 business days for all aspects of enrollment to be completed, including the availability of ID Cards.

IMPORTANT: Dependents are pending until this form and ALL supporting documentation has been received.

Return your completed form to the mailing address noted above.
You may also fax it directly to 603-666-4477 or email enrollment@myallegiantcare.com.
Retain a copy of this form for your records.

SECTION 1: MEMBER INFORMATION

Member's Full Name		SSN	Sex ❑ M ❑ F
Date of Birth	Marital Status: ❑ Single ❑ Married ❑ Separated ❑ Divorced ❑ Widowed		
Mailing Address	City	State	Zip Code
Primary Phone	E-mail Address		
Employer	Job Title	Local Union Number	
	Are you retired? ❑ Yes ❑ No	If yes, Date of Retirement:	

SECTION 2: SPOUSE/EX-SPOUSE INFORMATION (if no spouse, skip to Section 3)

Spouse's Full Name		SSN	Sex ❑ M ❑ F
Date of Birth	Date of Marriage (Must provide copy of state-issued Marriage Certificate)	Date of Divorce (if applicable) (Must provide copy of Divorce Decree)	
Mailing Address (if different)	City	State	Zip Code
Primary Phone	E-mail Address		
Spouse's Employer		❑ Not Employed	
Does this spouse or ex-spouse have any other insurance coverage? ❑ Yes ❑ No (If yes, complete Section 5)			

SECTION 3: OTHER DEPENDENT INFORMATION (if no other dependents, skip to Section 4)

1. Dependent's Full Name		SSN	Sex ❑ M ❑ F
Date of Birth	Relationship: ❑ Natural Child ❑ Step Child ❑ Adopted Child ❑ Other (specify)		
Does this dependent reside with you? ❑Yes ❑No	If no, name of parent/guardian with whom the child resides:		
Mailing Address (if different)	City	State	Zip Code
Does this dependent have other insurance through self or another guardian? ❑ Yes ❑ No (If yes, complete Section 5)			

2. Dependent's Full Name		SSN	Sex ❑ M ❑ F
Date of Birth	Relationship: ❑ Natural Child ❑ Step Child ❑ Adopted Child ❑ Other (specify)		
Does this dependent reside with you? ❑Yes ❑No	If no, name of parent/guardian with whom the child resides:		
Mailing Address (if different)	City	State	Zip Code
Does this dependent have other insurance through self or another guardian? ❑ Yes ❑ No (If yes, complete Section 5)			

SECTION 3: OTHER DEPENDENT INFORMATION (CONT.)

3. Dependent's Full Name		SSN	Sex ❑ M ❑ F
Date of Birth	Relationship: ❑ Natural Child ❑ Step Child ❑ Adopted Child ❑ Other (specify)		
Does this dependent reside with you? ❑Yes ❑No	If no, name of parent/guardian with whom the child resides:		
Mailing Address (if different)	City	State	Zip Code
Does this dependent have other insurance through self or another guardian? ❑ Yes ❑ No (If yes, complete Section 5)			

4. Dependent's Full Name		SSN	Sex ❑ M ❑ F
Date of Birth	Relationship: ❑ Natural Child ❑ Step Child ❑ Adopted Child ❑ Other (specify)		
Does this dependent reside with you? ❑Yes ❑No	If no, name of parent/guardian with whom the child resides:		
Mailing Address (if different)	City	State	Zip Code
Does this dependent have other insurance through self or another guardian? ❑ Yes ❑ No (If yes, complete Section 5)			

5. Dependent's Full Name		SSN	Sex ❑ M ❑ F
Date of Birth	Relationship: ❑ Natural Child ❑ Step Child ❑ Adopted Child ❑ Other (specify)		
Does this dependent reside with you? ❑Yes ❑No	If no, name of parent/guardian with whom the child resides:		
Mailing Address (if different)	City	State	Zip Code
Does this dependent have other insurance through self or another guardian? ❑ Yes ❑ No (If yes, complete Section 5)			

*** Make copies of this page if you have more than 5 dependents. ***

SECTION 4: MEDICARE COVERAGE

Are you or any dependents (including spouse) enrolled in Medicare? ❑ Yes ❑ No (if no, skip to Section 5)

1. Name of Eligible Person		Reason for Eligibility ❑ Age 65+ ❑ Disability ❑ End Stage Renal Disease (ESRD)		
Type ❑ Part A	Effective Date	Type ❑ Part B	Effective Date	Provide a copy of Medicare ID card

2. Name of Eligible Person		Reason for Eligibility ❑ Age 65+ ❑ Disability ❑ End Stage Renal Disease (ESRD)		
Type ❑ Part A	Effective Date	Type ❑ Part B	Effective Date	Provide a copy of Medicare ID card

2. Name of Eligible Person		Reason for Eligibility ❑ Age 65+ ❑ Disability ❑ End Stage Renal Disease (ESRD)		
Type ❑ Part A	Effective Date	Type ❑ Part B	Effective Date	Provide a copy of Medicare ID card

SECTION 5: OTHER INSURANCE INFORMATION (List each insurance company separately)

Do you or any of your dependents have other medical, dental, prescription or vision insurance coverage (besides Medicare), including insurance prior to enrolling in this Plan? ❑Yes ❑No (If no, skip to Section 6)

1. Insurance Company Name		Effective Date
ID Number	Group Number	Expiration Date (if applicable)
Subscriber's Full Name		Subscriber's DOB
List ALL individuals besides the subscriber who are covered by this policy:		
Type of Coverage Provided by this Carrier (check all that apply) ❑ Medical ❑ Prescription ❑ Dental ❑ Vision		Is this a Medicaid, State Insurance or HealthCare.gov plan? ❑ Yes ❑ No

2. Insurance Company Name		Effective Date
ID Number	Group Number	Expiration Date (if applicable)
Subscriber's Full Name		Subscriber's DOB
List ALL individuals besides the subscriber who are covered by this policy:		
Type of Coverage Provided by this Carrier (check all that apply) ❑ Medical ❑ Prescription ❑ Dental ❑ Vision		Is this a Medicaid, State Insurance or HealthCare.gov plan? ❑ Yes ❑ No

3. Insurance Company Name		Effective Date
ID Number	Group Number	Expiration Date (if applicable)
Subscriber's Full Name		Subscriber's DOB
List ALL individuals besides the subscriber who are covered by this policy:		
Type of Coverage Provided by this Carrier (check all that apply) ❑ Medical ❑ Prescription ❑ Dental ❑ Vision		Is this a Medicaid, State Insurance or HealthCare.gov plan? ❑ Yes ❑ No

***** If you and/or any dependent(s) had prior coverage that will be terminating, you must submit proof of cancellation or HIPAA Notice indicating date coverage ended*****

SECTION 6: CERTIFICATION

I certify that I am the subscribing member and all of the information provided on this form is complete and accurate. I understand it is a crime to knowingly provide false, incomplete or misleading information to obtain insurance or benefit coverage for the purpose of defrauding the Plan or insurance carrier. Penalties may include imprisonment, fines and/or denial of insurance benefits.

I understand I may not make any changes until Open Enrollment unless I have an approved Qualifying Event (*i.e.*, marriage, birth, adoption, divorce, change of employment or loss/gain of other insurance) and notify Allegiant Care within 30 DAYS of such an event. I understand I must also notify my employer if there is a change in my dependent status.

I understand all benefits are subject to conditions stated in the Plan document. I understand that Allegiant Care requires additional documentation, if applicable, before any dependent(s) are enrolled on my Plan.

Member Signature: _____ **Date:** _____

Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services
Allegiant Care: Open Access Plus OAPA8 - Plan 8

Coverage Period: 01/01/2024 - 12/31/2024
Coverage for: Individual/Individual + Family | **Plan Type:** OAP

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, go online at www.cigna.com/sp. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at https://www.healthcare.gov/sbc-glossary or call 1-800-Cigna24 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	For in-network providers: $0/individual or $0/family For out-of-network providers: $250/individual or $500/family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes, if your plan has a deductible in network Preventive care & immunizations, emergency room visits, Urgent care visits are covered before you meet your deductible	You will have to meet the deductible before the plan pays for any services.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	**Medical Co-insurance** For in-network providers **$1,000**/individual or **$2,000**/family For out-of-network providers **$4,000**/individual or **$8,000**/family **Medical Copay** in-network providers **$2,100** /individual or $4,200/ family **Prescription pharmacy**: in-network **$2,500** individual/ **$5,000** family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Penalties for failure to obtain pre-authorization for services, premiums, balance-billing charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.

Important Questions	Answers	Why This Matters:
Will you pay less if you use a network provider?	Yes. See www.cigna.com or call 1-800-Cigna24 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$15 copay/visit	20% coinsurance	None
	Specialist visit	$25 copay/visit	20% coinsurance	None
	Preventive care/ screening/ immunization	No charge	Not covered	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test x-ray blood work	No charge no charge	20% coinsurance Not covered	None
	Imaging (CT/PET scans, MRIs)	$100 copay per type of scan/day, plus 10% coinsurance	20% coinsurance	$250 penalty for no precertification.
If you need drugs to treat your illness or condition More information about	Generic drugs (Tier 1)	$15 co-pay/prescription (retail), $15 co-pay/prescription (home delivery)	Not covered	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
prescription drug coverage is available at www.myAllegiantrx.com	Preferred brand drugs (Tier 2)	$25 co-pay/prescription (retail), $25 co-pay/prescription (home delivery)	Not covered	If a generic is available, $25 copay/prescription (retail) plus the difference in cost between generic medication and the brand
	Non-preferred brand drugs (Tier 3)	$25 co-pay/prescription (retail), $25 co-pay/prescription (home delivery)	Not covered	If a generic is available, $25 copay/prescription (retail) plus the difference in cost between generic medication and the brand
	Specialty drugs (Tier 4)	$25 co-pay/prescription (home delivery)	Not covered	If a generic is available, $25 copay/prescription (retail) plus the difference in cost between generic medication and the brand
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	20% coinsurance	$250 penalty for no out-of-network precertification.
	Physician/surgeon fees	10% coinsurance	20% coinsurance	$250 penalty for no out-of-network precertification.
If you need immediate medical attention	Emergency room care	$100 copay/visit	$100 copay/visit Deductible does not apply	Per visit copay is waived if admitted. Out-of-network services are paid at the in-network cost share.
	Emergency medical transportation	No charge	No charge	Out-of-network air ambulance services are paid at the in-network cost share and deductible.
	Urgent care	$25 copay/visit	$25 copay/visit Deductible does not apply	None
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	20% coinsurance	$250 penalty for no out-of-network precertification.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Physician/surgeon fees	10% coinsurance	20% coinsurance	$250 penalty for no out-of-network precertification.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$15 copay/office visit No charge/all other services	20% coinsurance/office visit 20% coinsurance/all other services	$250 penalty if no precert of out-of-network non-routine services (i.e., partial hospitalization, etc.).
	Inpatient services	10% coinsurance	20% coinsurance	$250 penalty for no out-of-network precertification.
If you are pregnant	Office visits	No Charge	20% coinsurance	Primary Care or Specialist benefit levels apply for initial visit to confirm pregnancy. Depending on the type of services, a copayment, coinsurance or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	10% coinsurance	20% coinsurance	
	Childbirth/delivery facility services	10% coinsurance	20% coinsurance	
If you need help recovering or have other special health needs	Home health care	No charge	30% coinsurance	$250 penalty for no precertification. 16 hour maximum per day
	Rehabilitation services	$25 copay/ PCP or Specialist visit	30%coinsurance /visit **Chiropractic Care** Up to $30 reimbursement per visit. You will be responsible for all remaining charges	$250 penalty for failure to precertify speech therapy services. Coverage is limited to annual max of: 60 days for Rehabilitation and Cardiac rehab services; 34 days annual max for Chiropractic care services Limits are not applicable to mental health conditions for Physical, Speech and Occupational therapies.
	Habilitation services	$25 copay/ PCP or Specialist visit	30% coinsurance/visit	None
	Skilled nursing care	10% coinsurance	30% coinsurance	$250 penalty for no precertification. Coverage is limited to 120 days annual max.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Durable medical equipment	No charge	30% coinsurance	$250 penalty for no precertification.
	Hospice services	10% coinsurance/inpatient; No charge/outpatient services	30% coinsurance/inpatient; 30% coinsurance/outpatient services	$250 penalty for no precertification.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	None
	Children's glasses	Not covered	Not covered	None
	Children's dental check-up	Not covered	Not covered	None

Excluded Services & Other Covered Services:

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Cosmetic surgery
- Dental care (Adult)
- Dental care (Children)
- Eye care (Children)
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Prescription drugs
- Private-duty nursing
- Routine eye care (Adult)
- Routine foot care
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Acupuncture (Unlimited days)
- Bariatric Surgery (in-network only)
- Chiropractic care (34 days)
- Hearing aids up to age 19

Your Rights to Continue Coverage:
There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. Other coverage options may be available to you, too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights:
There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: Cigna Customer service at 1-800-Cigna24. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. Additionally, a consumer assistance program can help you file your appeal. Contact: New Hampshire Department of Insurance at (800) 852-3416.

Does this plan provide Minimum Essential Coverage? Yes
Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? Yes
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:
Spanish (Español): Para obtener asistencia en Español, llame al 1-800-244-6224.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-244-6224.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-800-244-6224.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-244-6224.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$0
Specialist copayment	$25
Hospital (facility) coinsurance	10%
Other coinsurance	0%

This EXAMPLE event includes services like:
Specialist office visits *(prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$30
Coinsurance	$1,000
What isn't covered	
Limits or exclusions	$10
The total Peg would pay is	**$1,040**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$0
Specialist copayment	$25
Hospital (facility) coinsurance	10%
Other coinsurance	0%

This EXAMPLE event includes services like:
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$1,100
Coinsurance	$0
What isn't covered	
Limits or exclusions	$200
The total Joe would pay is	**$1,300**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$0
Specialist copayment	$25
Hospital (facility) coinsurance	10%
Other coinsurance	0%

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$200
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$200**

The plan would be responsible for the other costs of these EXAMPLE covered services.

Plan Name: OAPA8 , Plan 8 **Ben Ver:** 28 **Plan ID:** 17122292

DISCRIMINATION IS AGAINST THE LAW

Medical coverage

Cigna complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Cigna does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Cigna:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact customer service at the toll-free number shown on your ID card, and ask a Customer Service Associate for assistance.

If you believe that Cigna has failed to provide theseservices or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance by sending an email to ACAGrievance@Cigna.com or by writing to the following address:

Cigna

Nondiscrimination Complaint Coordinator PO Box 188016
Chattanooga, TN 37422

If you need assistance filing a written grievance, please call the number on the back of your ID card or send an email to ACAGrievance@Cigna.com. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services 200
Independence Avenue, SW
Room 509F, HHH Building Washington, DC
20201
1.800.368.1019, 800.537.7697 (TDD)

Complaint forms are available at
http://www.hhs.gov/ocr/office/file/index.html.

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Proficiency of Language Assistance Services

English – ATTENTION: Language assistance services, free of charge, are available to you. For current Cigna customers, call the number on the back of your ID card. Otherwise, call 1.800.244.6224 (TTY: Dial 711).

Spanish – ATENCIÓN: Hay servicios de asistencia de idiomas, sin cargo, a su disposición. Si es un cliente actual de Cigna, llame al número que figura en el reverso de su tarjeta de identificación. Si no lo es, llame al 1.800.244.6224 (los usuarios de TTY deben llamar al 711).

Chinese – 注意：我們可為您免費提供語言協助服務。對於 Cigna 的現有客戶，請致電您的 ID 卡背面的號碼。其他客戶請致電 1.800.244.6224 （聽障專線：請撥 711）。

Vietnamese – XIN LƯU Ý: Quý vị được cấp dịch vụ trợ giúp về ngôn ngữ miễn phí. Dành cho khách hàng hiện tại của Cigna, vui lòng gọi số ở mặt sau thẻ Hội viên. Các trường hợp khác xin gọi số 1.800.244.6224 (TTY: Quay số 711).

Korean – 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 현재 Cigna 가입자님들께서는 ID 카드 뒷면에 있는 전화번호로 연락해주십시오. 기타 다른 경우에는 1.800.244.6224 (TTY: 다이얼 711)번으로 전화해주십시오.

Tagalog – PAUNAWA: Makakakuha ka ng mga serbisyo sa tulong sa wika nang libre. Para sa mga kasalukuyang customer ng Cigna, tawagan ang numero sa likuran ng iyong ID card. O kaya, tumawag sa 1.800.244.6224 (TTY: I-dial ang 711).

Russian – ВНИМАНИЕ: вам могут предоставить бесплатные услуги перевода. Если вы уже участвуете в плане Cigna, позвоните по номеру, указанному на обратной стороне вашей идентификационной карточки участника плана. Если вы не являетесь участником одного из наших планов, позвоните по номеру 1.800.244.6224 (TTY: 711).

Arabic – برجاء الانتباه خدمات الترجمة المجانية متاحة لكم. لعملاء Cigna الحاليين برجاء الاتصال بالرقم المدون على ظهر بطاقتكم الشخصية. او اتصل ب 1.800.244.6224 (TTY: اتصل ب 711).

French Creole – ATANSYON: Gen sèvis èd nan lang ki disponib gratis pou ou. Pou kliyan Cigna yo, rele nimewo ki dèyè kat ID ou. Sinon, rele nimewo 1.800.244.6224 (TTY: Rele 711).

French – ATTENTION: Des services d'aide linguistique vous sont proposés gratuitement. Si vous êtes un client actuel de Cigna, veuillez appeler le numéro indiqué au verso de votre carte d'identité. Sinon, veuillez appeler le numéro 1.800.244.6224 (ATS : composez le numéro 711).

Portuguese – ATENÇÃO: Tem ao seu dispor serviços de assistência linguística, totalmente gratuitos. Para clientes Cigna atuais, ligue para o número que se encontra no verso do seu cartão de identificação. Caso contrário, ligue para 1.800.244.6224 (Dispositivos TTY: marque 711).

Polish – UWAGA: w celu skorzystania z dostępnej, bezpłatnej pomocy językowej, obecni klienci firmy Cigna mogą dzwonić pod numer podany na odwrocie karty identyfikacyjnej. Wszystkie inne osoby prosimy o skorzystanie z numeru 1 800 244 6224 (TTY: wybierz 711).

Japanese – 注意事項:日本語を話される場合、無料の言語支援サービスをご利用いただけます。現在のCignaのお客様は、IDカード裏面の電話番号まで、お電話にてご連絡ください。その他の方は、1.800.244.6224 (TTY: 711)まで、お電話にてご連絡ください。

Italian – ATTENZIONE: Sono disponibili servizi di assistenza linguistica gratuiti. Per i clienti Cigna attuali, chiamare il numero sul retro della tessera di identificazione. In caso contrario, chiamare il numero 1.800.244.6224 (utenti TTY: chiamare il numero 711).

German – ACHTUNG: Die Leistungen der Sprachunterstützung stehen Ihnen kostenlos zur Verfügung. Wenn Sie gegenwärtiger Cigna-Kunde sind, rufen Sie bitte die Nummer auf der Rückseite Ihrer Krankenversicherungskarte an. Andernfalls rufen Sie 1.800.244.6224 an (TTY: Wählen Sie 711).

Persian (Farsi) – توجه: خدمات کمک زبانی، به صورت رایگان به شما ارائه می‌شود. برای مشتریان فعلی Cigna، لطفاً با شماره‌ای که در پشت کارت شناسایی شماست تماس بگیرید. در غیر اینصورت با شماره 1.800.244.6224 تماس بگیرید (شماره تلفن ویژه ناشنوایان: شماره 711 را شماره‌گیری کنید).

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Allegiant Care
HEALTH BENEFITS FOR TEAMSTERS

P.O. Box 4604 • 800.258.9732
51 Goffstown Road • 603.669.4771
Manchester, NH 03108 • f 603.666.4477

Life Insurance Beneficiary Designation

SECTION 1: MEMBER INFORMATION

Member's Full Name			SSN (last 4 digits)
Mailing Address	City	State	Zip Code
Marital Status	Employer		
Primary Phone ( )	E-mail Address		

SECTION 2: PRIMARY BENEFICIARIES

If you add multiple primary beneficiaries, the combined total percentage must equal 100%.

Full Name	Relationship	Date of Birth	SSN (required)	Percentage
Address, City, State, Zip				

Full Name	Relationship	Date of Birth	SSN (required)	Percentage
Address, City, State, Zip				

Full Name	Relationship	Date of Birth	SSN (required)	Percentage
Address, City, State, Zip				

Full Name	Relationship	Date of Birth	SSN (required)	Percentage
Address, City, State, Zip				

Full Name	Relationship	Date of Birth	SSN (required)	Percentage
Address, City, State, Zip				

Do you want to name any contingent beneficiaries? A contingent beneficiary will receive the life insurance benefit ONLY if there are no surviving primary beneficiaries.

☐ YES, I wish to add contingent beneficiaries. (complete Section 3 on Page 2)

☐ NO, I do not want to add contingent beneficiaries (complete Section 4 on Page 2)

SECTION 3: CONTINGENT BENEFICIARIES

Contingent Beneficiaries will receive the benefit ONLY if there are no surviving primary beneficiaries.

Full Name	Relationship	Date of Birth	SSN (required)	Percentage
Address, City, State, Zip				

Full Name	Relationship	Date of Birth	SSN (required)	Percentage
Address, City, State, Zip				

Full Name	Relationship	Date of Birth	SSN (required)	Percentage
Address, City, State, Zip				

SECTION 4: CERTIFICATION

I certify that I am the subscribing member and have designated my life insurance benefit to the beneficiary(ies) listed on this form. I understand the benefit is in effect as long as I am covered under a plan that offers life insurance and once I elect COBRA or retire the life benefit will cease. I understand it is my responsibility to contact Allegiant Care in the event a beneficiary needs to be added or removed.

Subscriber Signature: _____ **Date:** _____

FREQUENTLY ASKED QUESTIONS

Should I name a minor child as a beneficiary?

You may name a minor as a beneficiary; however, the child's guardian will need to provide proof of guardianship before the life insurance provider can make payment.

How do I name a Trust or an Estate as a beneficiary?

To name a trust or estate as a beneficiary, indicate the name of the trust and the date it was established.

Can I name someone other than my spouse as a beneficiary?

Generally, you can name anyone with whom you have a relationship as beneficiary. However, in community-property states, your spouse may have to sign a form waiving rights to the money if you designate anyone else as beneficiary. The community-property states are: Arizona, California, Idaho, Louisiana, Nevada, New Mexico, Texas, Washington, and Wisconsin.

If I have a will, do I still need to notify Allegiant Care when I change my beneficiaries?

Yes, it is very important to contact us if you want to change your beneficiary. The life insurance benefit will be paid to the beneficiary listed on the policy, regardless of what your will says.

Return your completed form to the mailing address noted on page 1.
You may also fax it directly to 603-792-7214 or email enrollment@myallegiantcare.com.
Retain a copy of this form for your records.