

## Enrollment or Change Form CIGNA International Dental Plan 00040A999



| [ ] New Mem                                |  |                      | [ ] Coverage Change    |                     | nange           |  |
|--|--|----------------------|------------------------|---------------------|-----------------|--|
|  | Effective D  | ate (AFSPA USE ONLY) |                        |                     |                 |  |
| Name                                       |  |                      |                        |                     |                 |  |
| Last                                       |  | Fir                  |                        |                     | M.I.            |  |
| Address                                    |  |                      |                        | irth                |                 |  |
| -  |  |                      |                        | Social Security #   |                 |  |
| Country                                    |  |                      |                        | Agency Name         |                 |  |
| Home Phone                                 |  |                      | Work Pho               | one                 |                 |  |
| E-mail Address                             |  |                      |                        |                     |                 |  |
| •  | · ·  | •                    | r any other group or   | -                   |                 |  |
| If "yes", give name o                      | of person covered  | and identify the     | e insurance carrier na | me, address and ID  | number:         |  |
|  |  | Dependent I          | nformation             |                     |                 |  |
| Spouse's Name                              | 's Name  |                      |                        | Date of Birth       |                 |  |
| pouse's SS#                                |  |                      |                        |                     |                 |  |
|  |  |                      |                        | or change of coverd |                 |  |
|  | **   | Children covere      | ed until age 26**      |                     |                 |  |
|  | Name   |                      | ,                      |                     | Gender<br>(M/F) |  |
|  |  |                      |                        |                     |                 |  |
|  |  |                      |                        |                     |                 |  |
|  |  |                      |                        |                     |                 |  |
|  |  |                      |                        |                     |                 |  |
| C  | overage Type   | Single [ ]           | Two-Party [ ]          | Family [ ]          |                 |  |
| В  | ill Me   | Quarterly [ ]        | Annually [ ]           |                     |                 |  |
| By my signature, I l<br>dental plan. AFSPA |  |                      |                        |                     | ernational      |  |
| Signature                                  | Date   |                      |                        |                     |                 |  |
| Send completed for                         | m to:  |                      |                        |                     |                 |  |
|  |  |                      |                        |                     |                 |  |
| Mail:                                      | American Foreign Service <b>Protective Association</b> 1620 L Street NW, Suite 800 |                      |                        |                     |                 |  |

**Fax:** (202) 775-9082

Online: http://www.afspa.org/secureform.cfm?FormName=Dental-Plan-Question

Washington, DC 20036