

I hereby request enrollment in the CIGNA HMO/PPO dental plan. AFSPA encourages enrollment for a minimum of one year.

Coverage Type	Single []	Two-Party []	Family []
Bill Me	Quarterly []	Annually []	

By my signature, I hereby request Membership in the Protective Association's Dental Program through CIGNA Dental.

I authorize payment of dental benefits to the provider of dental care.

I authorize any participating dental office to release dental records and billing information concerning me or my dependents to CIGNA Dental Health and Connecticut General Life Insurance Company for purposes of plan administration or for the purpose of validating and determining benefits payable. I further authorize CIGNA Dental Health and Connecticut General Life Insurance Company to release any records or information concerning me or my dependents to its designee, for purposes of plan administration and customer service.

Signature _____ Date _____

Please forward the completed form to AFSPA using the information below:

Mail:	American Foreign Service Protective Association 1620 L Street NW, Suite 800 Washington, DC 20036
Fax:	(202) 775-9082
Online:	https://www.afspa.org/secureform.cfm?FormName=Dental-Plan-Question