

Return completed form to:
Graduate Medical Education Office
910 Madison Avenue Suite 1031
Memphis, TN 38163

**THE UNIVERSITY OF TENNESSEE
THE HEALTH SCIENCE CENTER**

GRADUATE MEDICAL EDUCATION

**CIGNA
Health and Dental Insurance
RESIDENT FORM**

- NEW CONTRACT CHANGES TO EXISTING CONTRACT
 CHANGE MY ADDRESS AS BELOW
 CHANGE COVERAGE TO: INDIVIDUAL EMPLOYEE & SPOUSE EMPLOYEE & DEPENDENT FAMILY
 CHANGE MY NAME AS BELOW ADD DEPENDENTS DELETE DEPENDENTS

EFFECTIVE DATE OF CHANGE _____

REASON FOR CHANGE _____

LAST NAME _____ FIRST NAME _____ MI _____

SOCIAL SECURITY # _____ DATE OF BIRTH _____ SEX _____ PHONE# _____

MAILING ADDRESS _____ CITY _____ STATE _____ ZIP _____

DEPENDENT COVERAGE: YES _____ NO _____

	LAST NAME	FIRST NAME	Gender	DATE OF BIRTH	SOCIAL SECURITY #
SPOUSE:					
CHILD:					
CHILD:					
CHILD:					
CHILD:					

I ACKNOWLEDGE THE ABOVE REQUEST FOR ENROLLMENT/CHANGE IN MY HEALTH INSURANCE COVERAGE AND AUTHORIZE THE APPROPRIATE MONTHLY DEDUCTION FROM MY EARNINGS FOR THE TYPE OF COVERAGE SELECTED.

2009-2010 Monthly Premiums

- INDIVIDUAL (65.00) EMPLOYEE & SPOUSE (125.00) EMPLOYEE & CHILD(REN) (110.00) FAMILY (175.00)

SIGNATURE

DATE

UT GME OFFICE USE ONLY

DATE RECEIVED

EFFECTIVE DATE

LOCATION