Cigna® True Choice Medicare (PPO)

All information on this form is require by Center for Medicare Services, unless otherwise noted.

City Retiree First Name	MI	Last Name			Date of Birth
Enrollee First Name If different from above	**MI**	**Last Name**			**Date of Birth**

Mailing Address

Street		City	State	Zip Code

Physical Address

If you have a PO Box for a mailing address you <u>MUST</u> put a physical address or your application will be <u>REJECTED</u>

Street		City	State	Zip Code

Social Security Number	Medicare Number (MBI)
Are you enrolled or will be enrolling in Medicare A & B?	**If a new Medicare enrollee, when is your enrollment effective date?**
□ Yes □ No	

Phone number		Email address
	□ Cell □ Home	

Gender	Marital Status	Relationship to Retiree		Dept. Retiree Worked
		□ Self □ Medicare Dis. Dep. □ Spouse		

Insurance coverage other than Medicare?

□None   □ City's Cigna Plan   □ Other (Please complete information below)

Carrier	Policy Number	Policy Effective Date

Primary Care Provider (PCP)	Existing Patient?	
	□ Yes □ No	