

Return Completed Form To
 Graduate Medical Education Office
 960 East Third Street, Suite 104
 Chattanooga, TN 37403

**THE UNIVERSITY OF TENNESSEE HEALTH SCIENCE CENTER
 GRADUATE MEDICAL EDUCATION**

**CIGNA
 HEALTH AND DENTAL INSURANCE
 Resident/Fellow 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 _____ Middle I _____
 SS# _____ Date of Birth _____ Gender _____ Phone _____
 Local Address _____ City _____ State _____ Zip _____
 Dependent Coverage Yes No

	Last Name	First Name	Gender	Date of Birth	SS#
Spouse					
Child					
Child					
Child					
Child					

I acknowledge the above request for enrollment or change in my health and dental insurance coverage and authorize the appropriate monthly deduction from my earnings for the type of coverage selected.

2016-2017 Monthly Premiums

Individual (\$100) Employee & Spouse (\$200) Employee & Child(ren) (\$175) Family (\$275)

Signature

Date Signed

UT GME OFFICE USE ONLY

 Date Received _____
 Effective Date

UT College of Medicine Chattanooga Campus
 Location