HEALTHY HABITS FORM

Instructions for participant and program representative

- Print a copy of this form and bring it with you to the program's office.
- Fill out the Participant Information section. Answer every question. Form cannot be processed if incomplete.
- Your Program Representative should fill out the Program Representative section.
- Please be sure to write clearly, sign and date the form. **Forms without a signature and date are incomplete.**
- If you have any questions, call Customer Service at 1-888-992-4462.

Marking instructions

A B C D E 1 2 3 4 5

Shade like this → ●

Not like this → ⊗ ⊘

Forms may be sent by:

MAIL: Cigna Customer Service
PO Box 5201-5201
Scranton, PA 18505

FAX: 1.877.916.5406
Enter on the fax cover sheet: "CONFIDENTIAL"

ONLINE: Electronically upload your form at myCigna.com

PARTICIPANT INFORMATION

Relationship: Subscriber ○ Spouse/domestic partner ○ Gender: Male ○ Female ○

Participant's First Name | MI | Participant's Last Name

Street Address, Apt Number, PO Box

City | State | Zip

Participant Date of Birth
MM DD YYYY

Preferred Telephone Number

Is this a home ○ or cell ○ number?

Social Security (SSN) Last 4 numbers

Note: Please use the last 4 digits of patient's SSN

Participant's Cigna ID Number on ID card

Cigna Group Account Number on ID card

3 3 3 4 5 6 2

Customer Signature (required). My signature means that the information on this form is correct.

Today's Date MM DD YYYY

I understand that Cigna receives this information, and may use for determining my eligibility for incentives when applicable.
I understand that providing this authorization for Cigna and the employer-sponsored wellness program to collect my health information is voluntary under the employer wellness program.

PROGRAM REPRESENTATIVE INFORMATION (Please Print all Information)

As a Program Representative for the above-mentioned participant, I attest the participant has purchased and participated in the program(s) checked below.

☐ Fitness activity participation (gym membership, fitness classes, or fitness programs

☐ Weight loss program participation

_______# of sessions completed

Amount Paid for Program

Quarter: 1st 2nd 3rd 4th
Circle One

____
Year

Program Representative First Name | Program Representative Last Name

Program Representative Organization/Company

City | State | Zip

Signature of Program Representative (required)

Today's Date MM DD YYYY

Your Privacy is important: The privacy of your health information is important to you and to Cigna. We commit to protecting your personal health information. We ensure our practices comply with privacy laws, including the Health Insurance Portability and Accountability Act (HIPAA).

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