

Express App



Agent/Broker Use Only



Express App 2.0



- ❑ Flexibility to write business under virtually any scenario
- ❑ Minimize submission errors with dynamic capabilities to walk you through all application scenarios
- ❑ Easily access your prospects on the Homepage
- ❑ Floating resource links throughout the application process to provide support
- ❑ Navigation pane helps you follow along with the application pages, and allows you to move back and forth between different sections as necessary

www.CignaforBrokers.com

CSB Homepage

cigna Brokers TC TEST CBAGENT

Dashboard
Cigna Supplemental **1**
Quote and Enroll
Book of Business
Compensation
Sales & Marketing Materials
Incentives
Reporting
Training
Resource Center
Tools

MY MESSAGES

Welcome to Cigna for Brokers, Test

The information, tools, and resources you need to manage your business, all in one place.

Quote and Enroll

Cigna Supplemental Benefits

Book of Business

Cigna Supplemental Benefits

Tools

- CSB
- Express App
Cigna's quoting tool.
- Express Way
Recruit new Brokers.



www.CignaforBrokers.com

Express App 2.0

Cigna | EXPRESS APP Send Forms Welcome, TEST AGENT 1

Broker Campaigns: Create Self-Enroll Link

START A NEW QUOTE


1

2

Age

3

4





*For agent use only

[CSB Resources](#) [Dashboard](#)



Policy Selection

 | 

[Send Forms](#)

Getting Started

Policy Selection

End Quote

Disposition and Notes

Policy Selection initial premium \$0.00

Medicare Supplement (CHLIC)
Private health insurance designed to supplement original Medicare.
Insured by Cigna Health and Life Insurance Company

Medicare Supplement (ARLIC)
Private health insurance designed to supplement original Medicare.
Insured by American Retirement Life Insurance Company

Hospital Indemnity
Provides benefits for expenses incurred from hospital visits.
Insured by Loyal American Life Insurance Company

Flexible Choice Cancer/Heart Attack & Stroke
A Flexible Choice insurance policy helps you focus on your recovery, not your finances. Provides lump-sum benefits for diagnosis of cancer and/or heart conditions and stroke with the flexibility to add multiple riders for recurrence, restoration and more.
Insured by Loyal American Life Insurance Company

Cancer - Lump Sum

Heart - Lump Sum

APPLICANT 1

First Name

Last Name

Date of Birth

Age

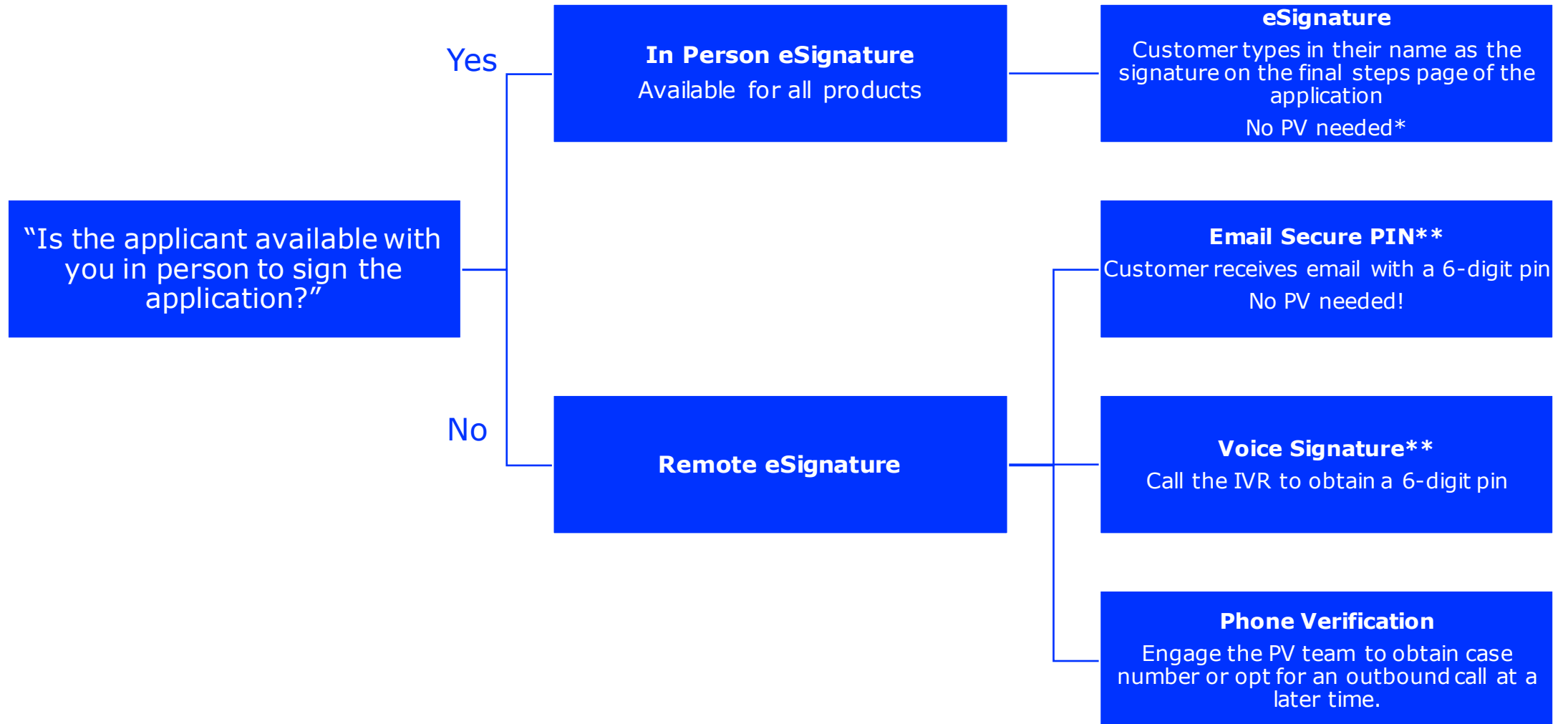
Gender (M/F)

Medicare Part A Effective Date

APPLICANT 2 +



eSignature Feature Breakdown



*Individual Whole Life and Short-Term Care policies require a phone verification whether in person or remote.
**Available only for UW Med Supp applications

Self-Enroll Link Personalized Link



Self-Enroll Link

Share CSB Products with your customers, leverage for cross selling strategies, and receive credit when customers self-enroll

1. Use the Create Self-Enroll link on Express App

> Ways to Share:

- ❖ Add to your Email Signature
- ❖ Email communication
- ❖ Social Media
- ❖ Personal Website

The screenshot displays the Cigna Express App interface. At the top left, the Cigna logo and 'EXPRESS APP' are visible. A 'Send Forms' button is located in the top right. The user is logged in as 'TEST AGENT 1'. Below the navigation bar, there is a 'Broker Campaigns' dropdown menu set to 'BROKERAGE' and a prominent blue button labeled 'Create Self-Enroll Link', which is highlighted by an orange arrow. The main content area is divided into two sections. On the left, a light blue box titled 'START A NEW QUOTE' contains input fields for 'Zip Code', 'Date of Birth', and 'Age', and a dropdown for 'Gender' (set to 'Please Select'). A green button at the bottom of this box reads 'QUICK QUOTE/APPLY'. On the right, there is a photograph of a smiling man with glasses and a young girl in a green shirt hugging him on a couch. At the bottom of the page, there are links for 'CSB Resources' and 'Dashboard'. A small asterisk note at the bottom left of the form area reads '*For agent use only'.

Choose Product and Copy Link

Cigna | EXPRESS APP Welcome, TEST AGENT 1

[Send Forms](#)

Broker Campaigns : [Create Self-Enroll Link](#)

START A NEW QUOTE

Zip Code

Date of Birth

Age

Gender

[QUICK QUOTE/APPLY](#)

*For agent use only

Create Self-Enroll Link

Writing Number

Cigna Line of Business

Type of product ⓘ

- Supplemental Health
- Supplemental Health
- Medicare Supplement

<https://cignasupplemental.com/equotes/startInterview.action?&cid>

Static Broker Link Breakdown

You can now decipher what the static broker link is for an agent without having to log in and generate it.

Example:

https://cignasupplemental.com/eqotes/startInterview.action?&cid=sbl&campaign_ID=BROKERAGE&ee=ANCORG&agentWritingNo=CB01234&companyId=12

Campaign ID

- Can be found in the top right corner on ExpressApp

EE

- ANCORG – Supplemental Product Offering
- CSBORG – Medicare Supplement

AgentWriting Number

- Agent writing number

Company Code

- Identifies the company assigned. This can be found on the commission statement.



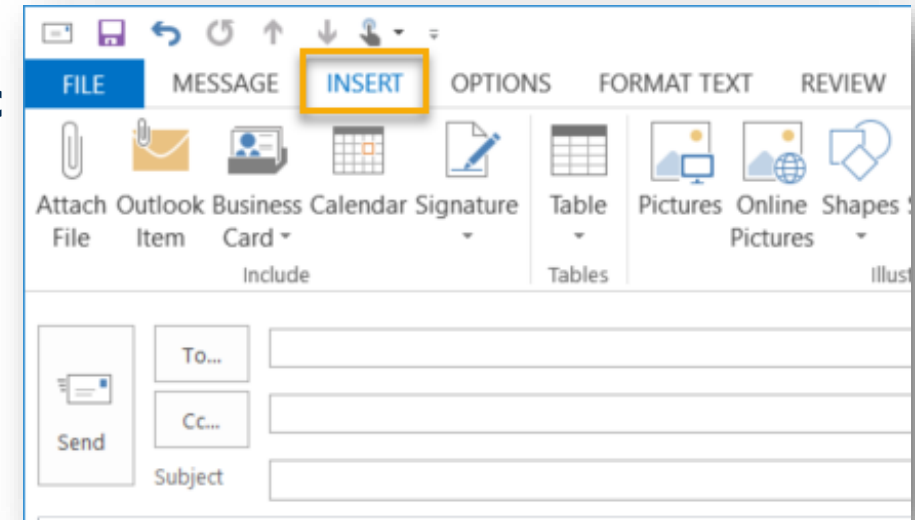
Customize Link in Email



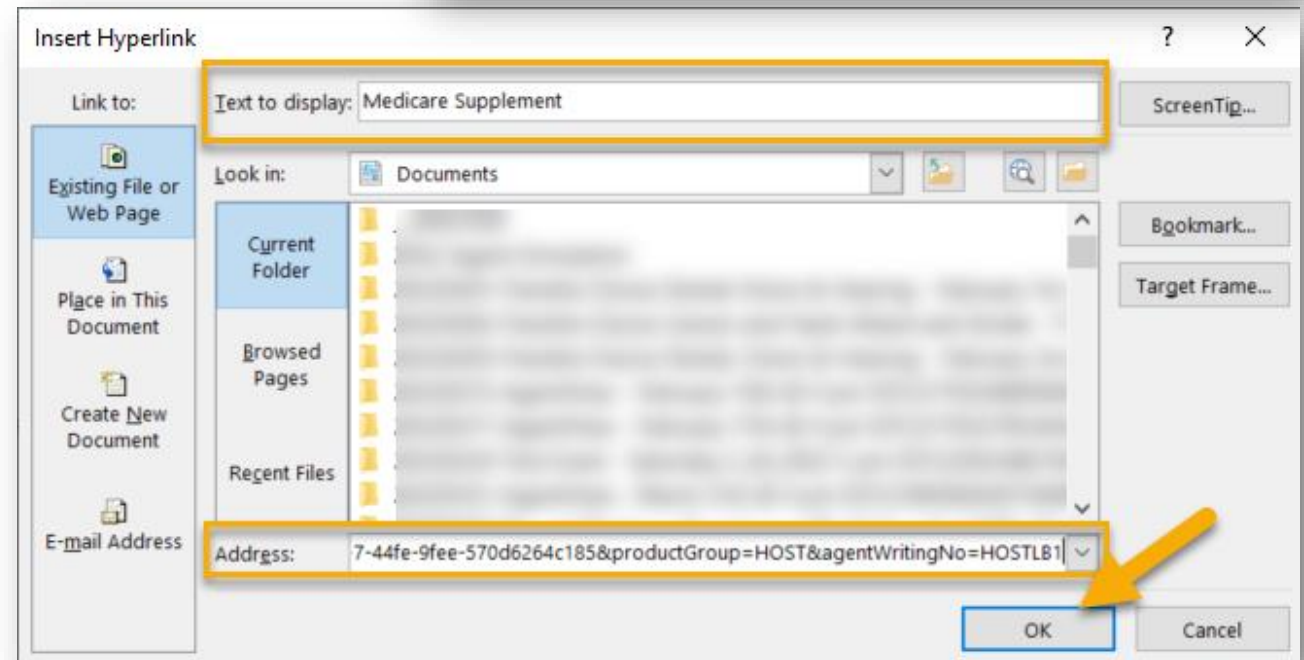
Outlook Customized Email

1. Customize the text for your Static Broker Link
 - A. Go to Outlook email
 - B. Open a new email message and click on the body of the email
 - C. Click the "Insert" tab and select the hyperlink icon
 - D. In the Insert Hyperlink Window:
 - I. Text to display = i.e. Medicare Supplement
 - II. Address = Paste your Static Broker Link
 - E. Click OK

Step C



Step D & E



Outlook Customized Email

2. Sample email containing the Static Broker Link

*Add to your email signature so that the Static Broker Link is included in all email communications

*Enrollment will be tied to you and your commissions

> Actively see in Express App:

- ❖ Any progress that has been completed by the applicant by clicking on the lead
- ❖ Submitted application

To... Kelly Wallace

Send Cc... Subject

Dear Kelly,


I enjoyed chatting with you earlier today. Below is a link to Cigna Medicare Supplement plan website where you can compare Medicare Supplement plans. Complete the short questionnaire to receive your quote for available plans.

Direct link to my Cigna Medicare Supplement plans to compare and enroll:
[Cigna Medicare Supplement Plans](#)

Sincerley,
John

John Smith
Cigna Supplemental Benefits
John.Smith@cigna.com
Cell: 309-430-5326

[Cigna Medicare Supplement Plans](#)
[Cigna Supplemental Health Plans](#)

 Cigna.

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Self-Enroll Link Customer Experience

Customer Experience

1. Customer is directed to a consumer facing site
2. Complete a questionnaire
 - ❖ Zip code
 - ❖ Name
 - ❖ Date of Birth
 - ❖ Gender
 - ❖ Medicare Information
 - ❖ Checks for Guarantee Issue
 - ❖ Available Discounts
 - ❖ Email and Phone number
3. Receive a Quote
4. Enroll in a Plan

Cigna Medicare Supplement Insurance
American Retirement Life Insurance Company
Cigna Health and Life Insurance Company
Cigna National Health Insurance Company
Loyal American Life Insurance Company

Medicare Supplement Insurance Quote

Get a Quote
Do you want to know what each of our Medicare Supplement plans cost?
Answer the following questions, and you can compare the costs of our plans right here on our website.

Where do you live?
Zip Code

Questions? Call us!
1-877-895-4619
Cigna Hours of Operation
Monday - Friday
8:00 am - 8:00 pm ET

Cigna Medicare Supplement Insurance
Cigna National Health Insurance Company

Medicare Supplement Insurance Quote

Your Medicare Supplement Quote

Plan G	Plan N	Plan A
per month \$109.40* Includes Premium Discount - \$6.98	per month \$78.39* Includes Premium Discount - \$5.00	per month \$96.11* Includes Premium Discount - \$6.13
Apply Now Learn More	Apply Now Learn More	Apply Now Learn More

Or contact your agent to apply

*Rates are subject to change. The policy's rate structure is based on attained age, which means your premium will increase each year due to increases in your age. Please do not send money. You must first complete an application to obtain coverage. Please see the Outline of Coverages for a brief description of the benefits. Programs included with your policy - at no additional cost to you!†

Cigna Healthy Rewards®
Discounts on health and wellness programs

Health Information Line
Speak with a health advocate† anytime
24 hours a day, 7 days a week

Personalized Link



Personalized Link

Use the Personalized Link to send an application for customer completion

1. Start the Application in Express App
2. Complete the Applicant Information
3. Use Send Forms

Personalized Link Requirements:

- ❖ Available only for
 - ❖ Flexible Choice Dental, Vision & Hearing
 - ❖ Medicare Supplements¹
- ❖ Requires monthly bank draft
- ❖ Payor must be the person enrolling
- ❖ Must send separate personalized link when multiple enrollees

1. Exceptions Loyal AK and DC.



Cigna | EXPRESS APP | FISHERS, IN

Getting Started

Applicant Information ✓

Dental Vision and Hearing (JAMES) \$44.84

Prior or Other Coverage

Billing Information

Customer First Name: JAMES

Customer Last Name: TEST

Customer Email: James.Test@tester.com

Verify Customer Email: James.Test@tester.com

Agent Phone Number: 610-423-5678

Agent Extn:

Agent Writing Number: HOSTLB2

Use the Send Forms button above to email your customer a personalized link to this in-progress dental application if they prefer to complete it without assistance.

You have indicated that you wish to send the proposal, application or required documents electronically. Please read the acknowledgement statement below to your applicant, and check the indication box. By accessing and opening the documents sent to you via the e-mail address that you have provided to us, you certify that: You

(i) consent and agree to receive disclosures, documents and notices electronically and confirm that you will download or print them for your records,

(ii) acknowledge that you have the ability to access the information that is provided electronically via email communications, and

(iii) acknowledge that such action constitutes your agreement and consent to receive electronic communications on a single use basis throughout the insurance purchasing process [i.e., from receipt of a proposal, completion of an application and continuing for thirty (30) days after you receive an issued policy sent to you through normal U.S. mail.]

Consent Acknowledgement

Required Documents

Include Customer Enrollment Link

Cancel Send Forms

NEXT >

Refer to the Plan Details document(s) any state-Texas, the Dental plan is known as Cigna Dental

Personalized Link Customer Experience

Customer Experience

1. Customer receives an email
2. Clicks on Proposal Information
3. Selects Apply Now
4. Directed to the consumer facing site to complete the application
5. All content captured by the Agent on the application is retained for the customers review, completion and submission

Hello TEST TEST,

Thank you for your interest. View the information we discussed at the links below.

[View your quote](#)



Ready to move forward?

If you have any questions, contact me directly.

[866-459-4272](tel:866-459-4272)

ASHLEY.HEATH@CIGNA.COM

[Choosing a Medigap Policy: A Guide to Health Insurance for People with Medicare](#)

Cigna Supplemental Benefits
Insured by Loyal American Life Insurance Company

Cigna Flexible Choice Dental, Vision & Hearing Insurance Quote

State Coverage: IN

Date: 10/06/2022

This customized quote is for: JAMES TESTER

Coverage Type: Primary Applicant

Preventive Services covered at 100%: Yes No

For more information, contact:

TRUMP ONE MICHAEL LB
610-423-5678
ejan.michael@cigna.com

Or access your quote and apply online!

[Apply Now](#) (Quote available for 90 days)

Cigna Flexible Choice Dental, Vision & Hearing Insurance

Plan	Annual Maximum	Deductible Amount
Flexible Choice	\$2,000	\$100



Cigna Supplemental Insurance
Loyal American Life Insurance Company

Cigna Supplemental Insurance Quote

Retrieve your Quote

Zip Code

Last Name

Date of Birth

Next

[VIEW STATE DISCLOSURES, EXCLUSIONS & LIMITATIONS](#)

Questions?



Contact your agent



PROPOSAL EMAIL

Hello TEST TEST,

Thank you for your interest. View the information we discussed at the links below.

[View your quote](#)



Ready to move forward?

If you have any questions, contact me directly.

[866-459-4272](tel:866-459-4272)

ASHLEY.HEATH@CIGNA.COM

[Choosing a Medigap Policy: A Guide to Health Insurance for People with Medicare](#)

Flexible Choice Dental, Vision & Hearing

[Outline of Coverage](#)

[Printable Application Packet](#)

Please visit the link below to review the Consent for Electronic Delivery.

[Consent for Electronic Delivery](#)



APPLY NOW

Cigna Supplemental Benefits Insured by Loyal American Life Insurance Company

Cigna Flexible Choice Dental, Vision & Hearing Insurance Quote

State Coverage: IN

Date: 10/06/2022

This customized quote is for: JAMES TESTER

Coverage Type: Primary Applicant

Preventive Services covered at 100%: Yes No

For more information, contact:

TRUMP ONE MICHAEL LB
610-423-5678
eljan.michael@cigna.com

Or access your quote and apply online!

[Apply Now](#) (Quote available for 90 days)

Cigna Flexible Choice Dental, Vision & Hearing Insurance		
Plan	Annual Maximum	Deductible Amount
Flexible Choice Dental & Vision	\$2,000	\$100
Monthly Electronic Funds Transfer (EFT)		
Premium Total*	\$44.84	

Exclusions, Limitations and Reductions

May vary by state, please see your outline of coverage or policy for exact details.

The benefits outlined broadly describe the benefits of our Flexible Choice Dental, Vision & Hearing policy. Availability varies by state. Policies may contain exclusions, limitations, reduction of benefits and terms under which the policy may be continued in force or discontinued. For costs and details of coverage, review your plan documents, consult your agent or contact a Cigna representative.

Please do not send money. You must first complete an application to obtain coverage. This is a solicitation for agent/producer may contact you. This proposal is designed as a marketing aid and is not to be construed as a contract. The full terms and conditions of coverage are stated in, and governed by, an issued policy. Forms series [LY-DVH-BA and LY-DVH-SCHD].

THIS POLICY PAYS LIMITED BENEFITS ONLY. THEY DO NOT CONSTITUTE COMPREHENSIVE HEALTH INSURANCE COVERAGE AND ARE NOT INTENDED TO COVER ALL MEDICAL EXPENSES. THIS COVERAGE DOES NOT SATISFY THE "MINIMUM ESSENTIAL COVERAGE" OR INDIVIDUAL MANDATE REQUIREMENTS OF THE AFFORDABLE CARE ACT (ACA). THIS COVERAGE IS NOT MEDICAID OR MEDICARE SUPPLEMENT INSURANCE.

*Premium amounts are based on information you provided and the issue age of the primary applicant. Premiums vary benefit amount and coverage type selected.



CONSUMER SITE



Cigna Supplemental Insurance
Loyal American Life Insurance Company

Cigna Supplemental Insurance Quote

Retrieve your Quote

Zip Code

Last Name

Date of Birth

Next

[VIEW STATE DISCLOSURES, EXCLUSIONS & LIMITATIONS](#)



Questions?



Contact your agent



Medicare Supplement



Medicare Supplement

The screenshot shows the 'Policy Selection' screen in the Cigna Express App. The initial premium is \$154.03. The interface is divided into several sections:

- Getting Started:** A sidebar menu with 'Policy Selection' highlighted.
- Policy Selection:** The main content area showing the selection of a Medicare Supplement (CNHIC) plan. It includes a table for two applicants, each with options for Plan A, Plan G, and Plan N. Discounts for household and living with someone are also shown.
- APPLICANT 1:** Personal information for the first applicant, including name, date of birth, age, gender, and Medicare effective dates.
- APPLICANT 2:** Personal information for the second applicant, including name, date of birth, gender, and Medicare effective dates.
- START APPLICATION:** A button at the bottom right to proceed with the application.

Callouts are placed as follows:

- 1:** Points to the 'Medicare Supplement (CNHIC)' section and the 'Coverage Applied for' options for both applicants.
- 2:** Points to the 'APPLICANT 1' and 'APPLICANT 2' information sections.
- 3:** Points to the 'Household Discount' and 'Living with Someone Discount' options.
- 4:** Points to the 'START APPLICATION' button.



Contact information and email

Applicant Information



Please use the Send Forms button above to send required pre-sale documents (application packet, customer booklet, proposals), as applicable.

Applicant 1

First Name

MI

Last Name

Date of Birth

Age

Gender

Phone

Email Address

Applicant declined to provide email

Resident Street Address (no PO Box)

1



Open Enrollment Guaranteed Issue Questions

Cigna | **EXPRESS APP** Send Forms ORLANDO, FL

Getting Started

- Applicant Information ✓
- Medicare Supplement (JAMES) \$122.36
- Open Enrollment/Guaranteed Issue Questions**
- End Application
- Disposition and Notes

Open Enrollment/Guaranteed Issue Questions

i NOTE: If you lost or are losing other health insurance coverage and received a notice from your prior insurer saying you were eligible for Guaranteed Issue of a Medicare Supplement insurance policy or that you had certain rights to buy such a policy, you may be guaranteed acceptance in one or more of our Medicare Supplement plans. Please send a copy of the notice from your prior insurer with the case number to (888) 695-2591. The case number will be provided via email after submission.

Attention! Based on your answers you qualify for Open Enrollment. Please be sure to review the plans offered under Open Enrollment.

We strongly encourage you to include the MBI on Open Enrollment (OE) applications for faster processing. If you don't have the Medicare number at the time of the submission for an OE application, please leave the field blank and we will pend the application until the Medicare number is received. The agent or applicant may provide the MBI by calling 877.454.0923 or fax to 888.695.2591.

Medicare Card No.

Medicare Part A Effective Date

PLEASE ANSWER ALL QUESTIONS

To the best of your knowledge:

Did you turn age 65 in the last six (6) months?
 Yes No

Did you enroll in Medicare Part B in the last six (6) months?
 Yes No

What is the effective date?

1



Some state applications may have additional fields

Review Plan Selection

Getting Started

Applicant Information ✓

Medicare Supplement (PLANHDGLSTBILMON DISCYESGI) \$55.31

Open Enrollment/Guaranteed Issue Questions ✓

Guaranteed Issue Right

Review Plan Selection

Replacement Notice

End Application

Disposition and Notes

GRPNAME

Group Number

776878

Guaranteed Issue Plans

<input type="checkbox"/> Plan A	\$132.51
<input type="checkbox"/> Plan F	\$220.48
<input type="checkbox"/> Plan G	\$134.53
<input checked="" type="checkbox"/> Plan HDG	\$55.31
<input type="checkbox"/> Plan N	\$104.97

Living with Someone Discount

Household Discount

Please provide details on the additional household member to qualify for the discount(s)*. Only one additional household member living at their current address is required to qualify for the discount(s). For Household Discount, provide SSN or Policy #.

First Name	MI	Last Name	Date Of Birth (MM/DD/YYYY)
FIRSTNAE	M	LASTANME	04/02/1950
SSN (Not required for LWS)	OR	Policy # (Not required for LWS)	
1 2 3 4 5 6 7 8 9		1 2 3 4 5 6 7 8 9	

*If more than one member of your household enrolls or is enrolled in a Medicare Supplement policy provided by or through an Affiliate of Cigna Insurance Company, you may qualify for a Household Discount; see the Outline of Coverage for details. Affiliate is defined as an insurance company that is under common ownership or control with Cigna Insurance Company and that is a member of the same insurance holding company system. Household is defined as a condominium unit, a single-family home, or an apartment unit within an apartment complex. Assisted Living Facilities, Group Homes, Adult Day Care facilities and Nursing Homes, or any other residential health facility are not included in the definition of "Household".

NEXT >



Some state applications may have additional fields

Medical Questions

Cigna | EXPRESS APP Send Forms

Getting Started

Applicant Information ✓

Medicare Supplement (MINERVA) \$78.39

Additional Info & Medicare ✓

Open Enrollment/Guaranteed Issue Questions ✓

Review Plan Selection ✓

Medical Questions

Marketing Authorization

End Quote

Disposition and Notes

Medical Questions

It is important that you provide truthful and accurate answers to the questions in this section as your answers form the basis of our determination of your eligibility for this coverage. Failure to provide complete and accurate information, if it is determined to be material to our assessment, may result in future denial of benefits and/or rescission of this coverage.

i PART A, MEDICAL QUESTIONS - If the answer to any question in Part A is YES, you are not eligible for coverage. If you answered NO to all questions in this Section, please continue to Part B.

Are you confined, scheduled for admission, or in the last two (2) years have you been confined to a nursing facility or assisted living facility?

Yes No

Do you receive home health care services; or in the last two (2) years, have you received home health care services for more than three (3) separate periods of care?

Yes No

Do you have a terminal illness; are you in the hospital, pending hospital admission, or have you been hospitalized more than two (2) times in the last two (2) years?

Yes No

Do you receive assistance bathing, transferring, toileting, eating, dressing, or are you bedridden; have you been advised by a medical professional to use the assistance of a wheelchair, walker, or motorized mobility aid?

Yes No

SAVE NEXT >



Some state applications may have additional fields

Medical Questions – Height & Weight and Medications

Getting Started

Applicant Information ✓

Medicare Supplement (MINERVA) \$78.39

Additional Info & Medicare ✓

Open Enrollment/Guaranteed Issue Questions ✓

Review Plan Selection ✓

Medical Questions

Marketing Authorization

End Quote

Disposition and Notes

- cerebral palsy, myasthenia gravis, systemic lupus, or Parkinson's disease?
- hepatitis other than hepatitis A, cirrhosis of the liver, or other liver disease?
- dementia, senility, or Alzheimer's disease?
- PSA levels greater than 6.0?

Yes No

Do you have now or in the last two (2) years have you been treated for or advised by a medical professional to have treatment for any of the following: angioplasty, atherosclerosis or arteriosclerosis, peripheral vascular disease, carotid artery disease, coronary artery disease (CAD), angina, cardiomyopathy, stent placement, heart valve surgery, atrial fibrillation, irregular heartbeat, cardiac pacemaker, implantable or subcutaneous defibrillator, transient ischemic attack (TIA)?

Yes No

1 Height & Weight Chart

Height (ft.) Height (in.) Weight (lbs.)

Have you taken or been prescribed any medications in the past two (2) years?

Yes No

Please list any prescription medications taken or prescribed in the past two (2) years.


Medication	Dates Taken (MM/DD/YYYY - MM/DD/YYYY)	Condition Taken For
<input type="text"/>	<input type="text"/>	<input type="text"/>

2 AGENT NOTES - Please provide any other information that you believe may assist in our underwriting determination:



Some state applications may have additional fields

Required Forms Page – HIPAA and Marketing Authorization

 **EXPRESS APP** Send Forms ORLANDO, FL

Getting Started

Applicant Information

Medicare Supplement (JAMES) \$122.50

Open Enrollment/Guaranteed Issue Questions

Review Plan Selection

HIPAA and Marketing Authorization

End Application

Disposition and Notes

HIPAA and Marketing Authorization

Marketing Authorization

I grant my authorization to receive information or presentation of materials describing other insurance products.

Yes No

HIPAA Authorization

AUTHORIZATION FORM FOR DISCLOSURE OF AN APPLICANT'S PROTECTED HEALTH INFORMATION

I hereby authorize the disclosure of protected health information about me as described below.

1. The Company, as used in this authorization, shall mean American Retirement Life Insurance Company, Loyal American Life Insurance Company®, Cigna Health and Life Insurance Company, Cigna National Health Insurance Company, and their affiliates as described below.
2. I authorize any licensed physician, medical practitioner, hospital, clinic, Pharmacy Benefit Manager, or other medical or medically-related facility, the U. S. Veterans Administration and Selective Service System, insurance company, MIB, Inc., or any other organization, institution, or person that has any records or information available as to the diagnosis, treatment, and prognosis with respect to any physical or mental condition and/or treatment relating to me or my family to disclose to the Company's underwriting, new business, claims, sales agents, and premium accounting representatives any such records or information. However, MIB, Inc., information will only be shared with the Company's underwriting staff and Medical Director.
3. I authorize the Company to make a brief report of my protected health information to MIB, Inc.
4. The protected health information described above will be disclosed to the Company to determine my or my family's eligibility to obtain coverage under the policy for which I/we have applied, and to determine the rates and terms which apply to the policy.
5. This medical or health information includes information on the diagnosis and treatment of mental illness, alcohol, and drug use. This also includes information on the diagnosis, treatment, and testing results related to HIV, AIDS, and sexually-transmitted diseases unless otherwise restricted by state law.
6. I understand that I may revoke this authorization in writing at any time, except to the extent that action has been taken by the Company in reliance on this authorization, by sending a written revocation to the Company's Privacy Office at PO Box 5700, Scranton, PA 18505-5700.
7. I understand that the information which will be provided under this authorization is necessary for the Company to determine my eligibility for coverage under the policy and that the

Required Forms Page - Agent Certification & Send Forms

1 Send Forms

2

3

4

Send Forms

Customer First Name: HOLLY

Customer Last Name: WOOD

Customer Email: MATTHEW.HOLMQUIST@CIGNA.COM

Verify Customer Email: MATTHEW.HOLMQUIST@CIGNA.COM

Agent Phone Number: 866-459-4272

Agent Extn:

You have indicated that you wish to send the proposal, application or required documents electronically. Please read the acknowledgement statement below to your applicant, and check the indication box. By accessing and opening the documents sent to you via the e-mail address that you have provided to us, you certify that: You

- (i) consent and agree to receive disclosures, documents and notices electronically and confirm that you will download or print them for your records,
- (ii) acknowledge that you have the ability to access the information that is provided electronically via email communications, and
- (iii) acknowledge that such action constitutes your agreement and consent to receive electronic communications on a single use basis throughout the insurance purchasing process [i.e., from receipt of a proposal, completion of an application and continuing for thirty (30) days after you receive an issued policy sent to you through normal U.S. mail.]

Consent Acknowledgement

Required Documents

Cancel Send Forms

SAVE NEXT



Some state applications may have additional fields

Required Forms page - In Person eSignature

Getting Started

Applicant Information ✓

Medicare Supplement (JAMES) \$143.77

Open Enrollment/Guaranteed Issue Questions ✓

Review Plan Selection ✓

Required Forms

End Application

Disposition and Notes

Name

Relationship

1. Have you been provided a blank copy of the application packet with any state specific disclosures, including HIPAA, Outline of Coverage and, if eligible for Medicare, a "Guide to Health Insurance for People with Medicare"?

Yes No

I certify that I have provided the Applicant with the following documents:

- a. Application packet *(phone sales only)*
- b. *Guide to Health Insurance for People with Medicare*
- c. Outline of Medicare Supplement Coverage
- d. Other:

I further certify that I have delivered the documents to the Applicant:*

Date:

Is the applicant available with you In Person to sign the application?

Yes No

SAVE

NEXT >

Billing Information

Getting Started

- Applicant Information ✓
- Medicare Supplement (MINERVA) \$117.30
- Additional Info & Medicare ✓
- Open Enrollment/Guaranteed Issue Questions - CA ✓
- Guaranteed Acceptance Situations ✓
- Review Plan Selection ✓ **1**
- Marketing Authorization ✓
- Billing Information**
- Agent Certification
- End Quote **2**
- Disposition and Notes

Billing Information

i Each policy is an individual contract and Third party/Company checks/payments and/or representative payees are not acceptable for payment of any premium, unless from an immediate family member or the payer is a Group/Association/Company and our Group/Association Direct/List Bill form has been submitted and approved for the billing process.

Please make sure you inform your customer that they will be drafted upon policy issue.

Payor is other than Insured
 Yes No

Account Information

Routing Number

Routing Number
122105278
Routing number could not be validated. Please re-enter the information.

Account Type
Please Select **3**

Account Number
000000005 **4**
Account number could not be validated. Please re-enter the information.

Requested Withdrawal Date (1 - 28)

Bank Consent Verification Questions
(To be completed by Bank Account Owner/Depositor)

SAVE **NEXT >**



Some state applications may have additional fields

Acknowledgement of Nonduplication

Cigna EXPRESS APP LAREDO, TX

Acknowledgement Of Nonduplication

ACKNOWLEDGMENT OF NONDUPLICATION

NOTICE TO CONSUMERS
Age 65 and older

This Notice is required by the Texas Department of Insurance because of its concern that some consumers may buy unnecessary coverage or may replace their coverage needlessly. Buying too much coverage or replacing a policy may be a waste of your money.

1. Does the applicant have any of the following health coverages in force?
• SPECIFIED DISEASE (CANCER, STROKE, ETC.)
• HOSPITAL INDEMNITY
• BASIC HOSPITAL EXPENSE OR BASIC MEDICAL/SURGICAL
• EXPENSE (THESE POLICIES ARE TYPIFIED BY A SCHEDULED BENEFIT PER ILLNESS)
• LONG-TERM CARE

Yes No

I have reviewed the following policies and found that duplication WILL or WILL NOT occur.

Will Will Not

Company: Policy Type:

Policy Number: Form Number:

Does the applicant intend to replace coverage?
 Yes No

Duplication will not occur because the above listed policy(ies) numbers will be replaced by the applied for policy. Justification for the replacement is:

Duplication will not occur No health policies in force at this time Applicant has elected not to have the policy(ies) reviewed

I certify that my right to have all my existing health policies examined has been explained to me by the agent named above.

I have chosen to waive my right to have my policies reviewed to determine if they unnecessarily duplicate each other. My policies have been reviewed.

The policy for which I am applying WILL or WILL NOT result in duplicate coverage.
 Will Will Not

Final Steps – eSignature options

In-Person

The screenshot shows the 'Final Steps' section of an application. On the left is a navigation menu with items: Applicant Information (checked), Medicare Supplement (JAMES) \$143.77, Open Enrollment/Guaranteed Issue Questions (checked), Review Plan Selection (checked), Required Forms (checked), Billing Information, State Required Form(s), Acknowledgement Of Nonduplication, Final Steps (highlighted), End Application, and Disposition and Notes. The main content area is titled 'Final Steps' and shows 'PRODUCT: Medicare Supplement' and 'Agent Acceptance' with a 'Requested Effective Date (MM/DD/YYYY)' field. Below this is an 'SSN/ITIN' field. Two questions are listed: '1. Do you attest that the information you provided on the application is accurate, complete and true?' and '2. I understand that I have applied electronically for insurance and that by providing an answer to the security question and security pin number, this will be considered an effective and binding signature.' Both have radio buttons for 'Yes' and 'No'. A blue-bordered information box contains an 'i' icon and text: 'Applicant Electronic Signature. Please request the applicant to physically enter First Name, Middle Initial (if applicable), and Last Name in the same format as it was previously entered on the application. Upon submission this will constitute the electronic signature of the Application, Payment Authorization, Health Information Authorization, Electronic Consent and any other required forms. For example: Populate customer name as it appears on the Applicant Info Page. JAMES TESTER. Please forego any special characters in the signature field.' Below this is a field labeled '*Applicant Electronic Signature:'.

Remote

The screenshot shows the 'Final Steps' section of an application for 'MOODY, AL'. The navigation menu on the left includes: Applicant Information (checked), Medicare Supplement (RERETGR) \$192.62, Open Enrollment/Guaranteed Issue Questions (checked), Review Plan Selection (checked), Medical Questions (checked), Required Forms (checked), Billing Information (checked), Arbitration (checked), Final Steps (highlighted), Lump Sum Cancer \$266.75, Additional Information, End Application, and Disposition and Notes. The main content area shows 'PRODUCT: Medicare Supplement' and 'Agent Acceptance' with a 'Requested Effective Date (MM/DD/YYYY)' field containing '08/01/2023' and an 'SSN/ITIN' field containing '1'. Below these are radio buttons for 'Email Secure PIN', 'Voice Signature' (selected), and 'Phone Verification'. A blue-bordered information box contains an 'i' icon and text: 'Click "Send Forms" to capture the customer's e-signature. Upon clicking "Send Forms" the customer will be emailed the following documents: Outline of Coverage, Guide to Health Insurance for People with Medicare, Insurance Application, Payment Authorization, Health Information Authorization, E-Forms Consent. The email will contain a link for the customer to navigate to a website where the customer has to agree to all attestation. Upon agreeing to all attestations, the site will display an auto-generated 6-digit PIN. The customer should verbally provide the PIN for the agent to enter below. This PIN serves as the customer's e-signature.'



Some state applications may have additional fields

In-Person eSignature

When can I do an In-Person eSignature?

- ✓ In-person eSignature is available for all in person applications regardless if going through underwriting or not.
- ✓ Must be physically in person (Webex/Zoom meetings are not valid)

How do I capture the eSignature?

- ✓ Customer types their name as signature on the Final Steps page, verifying the information is accurate & accepting disclosures

What other steps do I need to take?

- ✓ No other steps are needed. In fact, this option replaces the phone verification for all in person sales except for Individual Whole Life and Short-Term Care, making it a better experience for both you and our customers.

The screenshot displays the 'Final Steps' section of an application. On the left, a sidebar lists various steps with green checkmarks, including 'Applicant Information', 'Medicare Supplement (JAMES) \$143.77', 'Open Enrollment/Guaranteed Issue Questions', 'Review Plan Selection', 'Required Forms', 'Billing Information', 'State Required Form(s)', and 'Acknowledgement Of Nonduplication'. The 'Final Steps' section is highlighted in blue. Below it, the 'End Application' section is visible, including a 'Disposition and Notes' field.

The main content area is titled 'Final Steps' and shows the 'PRODUCT: Medicare Supplement' and 'Agent Acceptance' section. It includes a 'Requested Effective Date (MM/DD/YYYY)' field and an 'SSN/ITIN' field. Below these are two questions with radio button options for 'Yes' and 'No':

1. Do you attest that the information you provided on the application is accurate, complete and true?
 Yes No
2. I understand that I have applied electronically for insurance and that by providing an answer to the security question and security pin number, this will be considered an effective and binding signature.
 Yes No

The 'Applicant Electronic Signature' section is highlighted with a red border. It contains an information icon and the following text:

Applicant Electronic Signature

Please request the applicant to physically enter First Name, Middle Initial (if applicable), and Last Name in the same format as it was previously entered on the application. Upon submission this will constitute the electronic signature of the Application, Payment Authorization, Health Information Authorization, Electronic Consent and any other required forms.

For example:
Populate customer name as it appears on the Applicant Info Page
JAMES TESTER
Please forego any special characters in the signature field.

Below this is a text input field labeled '*Applicant Electronic Signature:' with a red border around it.



Remote eSignature

What are the Remote eSignature options?

- ✓ Available in 3 distinct options
 - Email + Secure Pin
 - Voice Signature
 - Phone Verification

Remote eSignature: Email + Secure Pin

Who is Email + Secure Pin available for?

- ✓ Available only for underwritten (UW) Medicare Supplement applications.

How do I complete the Email + Secure Pin step?

- ✓ Select "Send Forms" button to email the customer all required documents along with a link with attestations and the 6-digit pin
- ✓ Have customer verbally provide this to you and enter it on the application.

What other steps do I need to take?

- ✓ No other steps are needed. In fact, this option replaces the phone verification for all Med Supp remote sales, making it a better experience for both you and our customers.

Cigna. EXPRESS APP

Getting Started

Applicant Information ✓

Medicare Supplement (TEST) \$162.67

Open Enrollment/Guaranteed Issue Questions ✓

Review Plan Selection ✓

Medical Questions ✓

Required Forms ✓

Billing Information

State Required Form(s)

Acknowledgement Of Nonduplication

Final Steps

End Application

Disposition and Notes

Send Forms

Signature Options:

Email Secure PIN Voice Signature Phone Verification

i Click 'Send Forms' to capture the customer's e-signature.

- Upon clicking 'Send Forms' the customer will be emailed the following documents:
 - Outline of Coverage
 - Guide to Health Insurance for People with Medicare
 - Insurance Application
 - Payment Authorization
 - Health Information Authorization
 - E-Forms Consent
- The email will contain a link for the customer to navigate to a website where the customer has to agree to all attestations.
- Upon agreeing to all attestations, the site will display an auto-generated 6-digit PIN.
- The customer should verbally provide the PIN for the agent to enter below. This PIN serves as the customer's e-signature.

Enter the authorization code provided by the applicant to apply the electronic signature to the Application, Payment Authorization, Health Information Authorization and Electronic Consent:

7HHB2E

Agent(s) shall list any health insurance policies sold to the Applicant.

List any other health policies or coverages sold to the Applicant which are still in force (if this does not apply, state "NONE").



Remote eSignature: Voice Signature

Who is Voice Signature available for?

- ✓ Available only for underwritten (UW) Medicare Supplement applications.

How do I complete the Voice Signature step?

- ✓ Call 800-234-6933 on a three-way line
- ✓ Have customer verify their information to the IVR.
- ✓ Capture the 6-digit secure voice pin provided

What other steps do I need to take?

- ✓ No other steps are needed. In fact, this option replaces the phone verification for all Med Supp remote sales, making it a better experience for both you and our customers.

The screenshot displays the Cigna Express App interface for a Medicare Supplement application. The left sidebar shows a progress list with 'Final Steps' highlighted. The main content area is titled 'Final Steps' and includes a 'Send Forms' button in the top right corner. The location is identified as 'LAREDO, TX'. The application details show 'PRODUCT: Medicare Supplement' and 'Agent Acceptance'. There are input fields for 'Requested Effective Date (MM/DD/YYYY)' and 'Applicant SSN/ITIN'. A red box highlights the 'Signature Options' section, which includes radio buttons for 'Email Secure PIN', 'Voice Signature' (which is selected), and 'Phone Verification'. Below this, there is a text prompt: 'Complete your application using Voice Signature now and get the policy issued faster! Simply call 800.234.6933 with your applicant and enter the applicant's secure 6-digit PIN in the space provided below.' This is followed by an input field labeled 'Enter the Six Digit Secure Voice Pin'. At the bottom, there are instructions for PIN values and a note for agents to list other health policies.



Phone Verification

What is a Phone Verification (PV)?

- ✓ Phone Interview that the applicant must^{1,2} complete
- ✓ Acts as an electronic signature
- ✓ Verifies medical questions

Where do I call?

- ✓ PV Line 866.825.4822 Monday – Friday 7 a.m. to 6 p.m. CT

What is a Case Number?

- ✓ Confirmation of the PV
- ✓ Provided to applicant to be included on application

Complete the PV at point of sale

- ✓ Applications processed faster
- ✓ Commissions paid faster

For Pre-Qualification questions, speak to an Underwriting Specialist @ 877.454.0923, option 3
FAQs and additional information available @ CignaforBrokers.com

Getting Started

- Applicant Information ✓
- Medicare Supplement (TEST) \$162.67
- Open Enrollment/Guaranteed Issue Questions ✓
- Review Plan Selection ✓
- Medical Questions ✓
- Required Forms ✓
- Billing Information
- State Required Form(s)
- Acknowledgement Of Nonduplication
- Final Steps**
- End Application
- Disposition and Notes

Final Steps

PRODUCT: Medicare Supplement

Agent Acceptance

Requested Effective Date (MM/DD/YYYY)

10/01/2023

SSN/ITIN

Signature Options:

Email Secure PIN Phone Verification Voice Signature

Complete the Phone Verification (PV) now and get the policy issued faster! Simply call 866.825.4822 Mon-Fri, 7am to 6pm CST with your applicant and write your PV Case # in the space provided below.

Has a Phone Verification been completed?

Yes No

Best Time to Call

Please Select

PV Case #



1. Only applicable to Individual Whole Life, Short-Term Care or over \$50,000 in combined Supplemental Health coverage remote sales
2. When an underwritten Medicare Supplement customer cannot complete other eSignature options.

Phone verification

When does my customer need a PV?

Live PV: 7am to 6pm Central, Mon – Fri 866-825-4822				
Product		EXPRESS APP (no Wet Signature)	Phone/Fax (no wet signature)	Paper/Fax (with wet signature)
Medicare Supplement	OE/GI	Not needed ¹	Live PV	Not needed ¹
	Underwritten	Not needed ²	Live PV	Live PV
Cancer, Heart Attack & Stroke, Hospital Indemnity, and Accident		Not needed ³	Live PV	Not needed
Individual Whole Life		Live PV	Live PV	Live PV

For Pre-Qualification questions, you can speak to an Underwriting Specialist by calling New Business at 877.454.0923, option 3.



1. Applicant verification in lieu of a PV.
2. Only if Email + Secure Pin could not be complete
3. Flexible Choice over \$50,000 require live PV when not in person.

Document Upload

Getting Started

- Applicant Information ✓
- Medicare Supplement (HOLLY) \$113.40
- Open Enrollment/Guaranteed Issue Questions ✓
- Review Plan Selection ✓
- Medical Questions ✓
- HIPAA and Marketing Authorization ✓
- Billing Information ✓
- State Required Form(s) ✓
- Final Steps**
- End Application
- Disposition and Notes

If you need assistance filing a written grievance, please call 1.800.455.4272 (TDD: Dial 711), or send an email to ACAGrievance@Cigna.com. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, DC 20201
1.800.868.1019, 800.537.7697 (TDD)
Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

I certify that I have interviewed the Applicant, asked all of the questions as written on the form, and provided the information to the Applicant. I certify that all of the information given in the Agent Certification Section is true and correct.

Commissions

Licensed Agent's First Name	Licensed Agent's Last Name
TEST	AGENT 1

Comments

Would you like to upload any documents electronically to your application?
We recommend you provide GI proof, Power of Attorney (POA) documentation or any other documents that may be required for your application.

Yes No

1

2 **UPLOAD**

Upload Document

Document Type
Please Select

Document Title

Document
Choose File No file chosen

Cancel Upload



Some state applications may have additional fields

Submitting the application

Cigna | **EXPRESS APP**

Getting Started	
Applicant Information	✓
Medicare Supplement	\$146.06
Additional Info & Medicare	✓
Open Enrollment/Guaranteed Issue Questions	✓
Review Plan Selection	✓
Medical Questions	✓
Marketing HIPAA	✓
Med Supp HIPAA	✓
Billing Information	✓
Agent Certification	✓
Arbitration	✓
Review And Accept	✓
Submit	
Medicare Supplement (JOHN)	\$127.98
Additional Info & Medicare	
Review Plan Selection	

Submit ¹

Successfully Submitted Your Application. Your Application ID is EX000005EK. This is not your applicant's CSB case number. You will receive an email once the application is received and assigned to New Business for processing that will include your applicant's CSB case number. Your application ID may be used in the event that technical troubleshooting is needed.

ATTENTION: Please check the Navigation bar for any additional applicants or products to be applied for. If additional coverage is to be applied for, please click on **ADDITIONAL INFORMATION** under the next product in the Navigation Bar. To return to the homepage, click on the blue **EXPRESS APP** home button.

²

Additional Scenarios

Multiple applicants and charters

1

Medicare Supplement (CHLIC)
Private health insurance designed to supplement original Medicare. Insured by Cigna Health and Life Insurance Company.

Applicant 1
Rate Class* Preferred
Payment Method / Mode EFT - Monthly

Coverage Applied for

Plan A \$102.99	Plan F \$127.45	Plan HDF \$36.49	Plan G \$101.54	Plan N \$84.98
-----------------	------------------------	------------------	-----------------	----------------

Applicant 2
Rate Class* Preferred

Coverage Applied for

Plan A \$120.80	Plan F \$149.50	Plan HDF \$42.80	Plan G \$101.54	Plan N \$84.98
-----------------	-----------------	------------------	-----------------	----------------

*For attained age and issue age, during Open Enrollment (OE) and guaranteed issue, plans should be quoted at the Preferred (nontobacco user) rate for the applicant's age, regardless of tobacco use.

Household Discount - \$9.59

NOTE: If another member of your household is applying for or currently has a Medicare Supplement plan with an affiliated company, you may qualify for a household discount; see the Outline of Coverage for details. You must provide the name and Social Security Number (SSN) of the individual(s) living at your current address during the application process.

[View Blank Application \(CHLIC\)](#)
[View Brochure \(CHLIC\)](#)

2

Medicare Supplement (ARLIC)
Private health insurance designed to supplement original Medicare. Insured by American Retirement Life Insurance Company.

Applicant 1
Rate Class* Standard II
Payment Method / Mode EFT - Monthly

Coverage Applied for

Plan A \$221.24	Plan F \$271.02	Plan G \$242.71	Plan N \$191.05
-----------------	-----------------	-----------------	-----------------

Applicant 2
Rate Class* Preferred
Payment Method / Mode EFT - Monthly

Coverage Applied for

Plan A \$171.50	Plan F \$201.25	Plan G \$167.65	Plan N \$124.57
-----------------	-----------------	------------------------	-----------------

*For attained age and issue age, during Open Enrollment (OE) and guaranteed issue, plans should be quoted at the Preferred (nontobacco user) rate for the applicant's age, regardless of tobacco use. Please note the Standard II (nontobacco user) and Standard III (tobacco user) rate classes apply to ARLIC only.

Household Discount - \$12.62

NOTE: If another member of your household is applying for or currently has a Medicare Supplement plan with American Retirement Life Insurance Company or an affiliated company, you may qualify for a Household Discount; see the Outline of Coverage for details. Please provide the name and Social Security number of the individual(s) living at your current address.

Per Applicant One-time Policy Fee: \$6.00

[View Blank Application](#)
[ARLIC Medicare Supplement Brochure](#)
[Value Add Brochure](#)

APPLICANT 1

First Name
SERDO

Last Name
WOOLLEY

Date of Birth
01/02/1955

Age
65

Gender (M/F)
Female

Medicare Part A Effective Date
12/01/2020

APPLICANT 2

First Name
CEDRIC

Last Name
WOOLLEY

Date of Birth
02/01/1960

Gender
Male

Medicare Part A Effective Date

3

START APPLICATION ➔



Multiple applicants and products

1

Medicare Supplement (CHLIC)
Private health insurance designed to supplement original Medicare, insured by Cigna Health and Life Insurance Company

Applicant 1

Rate Class* Preferred Payment Method / Mode EFT - Monthly

Coverage Applied for

Plan A \$102.99	Plan F \$127.45	Plan HDF \$36.49	Plan G \$101.54	Plan N \$84.98
-----------------	------------------------	------------------	-----------------	----------------

Applicant 2

Rate Class* Preferred

Coverage Applied for

Plan A \$120.80	Plan F \$149.50	Plan HDF \$42.80
-----------------	-----------------	------------------

*For attained age and issue age, during Open Enrollment (OE) and guaranteed issue, plans should be quoted at regardless of tobacco use.

Household Discount -\$9.59

NOTE: If another member of your household is applying for or currently has a Medicare Supplement affiliated company, you may qualify for a household discount; see the Outline of Coverage for details. Security Number (SSN) of the individual(s) living at your current address during the application.

[View Blank Application \(CHLIC\)](#)

[View Brochure \(CHLIC\)](#)

2

Flexible Choice Cancer/Heart Attack & Stroke
A Flexible Choice insurance policy helps you focus on your recovery, not your finances. Provides lump-sum benefits for diagnosis of cancer and/or heart conditions and stroke with the flexibility to add multiple riders for recurrence, restoration and more. Insured by Loyal American Life Insurance Company

Cancer - Lump Sum

Provides lump sum benefits if you are diagnosed with cancer while your policy is in force along with maximum rider flexibility. Insured by Loyal American Life Insurance Company

Take a look at these Key Features!

Coverage Type	Payment Mode/Method	Total Lump Sum Cancer Premium
Individual & Spouse/Civil Union Partner/Domestic Partner	EFT - Monthly	\$28.00
<input type="checkbox"/> Cancer Recurrence Benefit Rider		\$2.25
<input type="checkbox"/> Lump Sum Heart/Stroke Rider	\$5,000	\$29.50
<input type="checkbox"/> Lump Sum Cancer Builder Rider	\$500	\$13.62
<input type="checkbox"/> Radiation And Chemotherapy Rider	Prime	\$9.61
<input type="checkbox"/> **Specified Disease Benefit Rider	\$5,000	\$6.06
<input type="checkbox"/> Accident Fixed Indemnity Rider	Prime	\$28.00
<input type="checkbox"/> *Hospital Indemnity Rider	\$100	\$16.60
<input type="checkbox"/> *Intensive Care Unit Rider	\$100	\$3.30
<input type="checkbox"/> *Hospital and Intensive Care Unit Indemnity Rider	\$100	\$18.80
<input type="checkbox"/> Return of Premium Upon Death Rider		\$21.00

**BENEFIT AMOUNT MUST BE LESS THAN OR EQUAL TO THE LUMP SUM CANCER POLICY BENEFIT AMOUNT AND CANNOT EXCEED \$50,000

[View Blank Application](#)

[Flexible Choice Cancer Brochure](#)

*PLEASE ADVISE THE APPLICANT: THIS IS A SUPPLEMENT TO HEALTH INSURANCE AND IS NOT A SUBSTITUTE FOR MAJOR MEDICAL COVERAGE. LACK OF MAJOR MEDICAL COVERAGE (OR OTHER MINIMUM ESSENTIAL COVERAGE) MAY RESULT IN AN ADDITIONAL PAYMENT WITH YOUR TAXES.

APPLICANT 1

First Name
SERDO

Last Name
WOOLLEY

Date of Birth
01/02/1955

Age
65

Gender (M/F)
Female

Medicare Part A Effective Date
12/01/2020

APPLICANT 2

First Name
CEDRIC

Last Name
WOOLLEY

Date of Birth
02/01/1960

Gender
Male

Medicare Part A Effective Date

3

START APPLICATION >



Scroll down to see all products available for the state indicated



Flexible Choice Dental, Vision, & Hearing



Dental, Vision, & Hearing Policy Selection

Policy Selection initial premium \$0.00

1 Flexible Choice Dental, Vision & Hearing

	Payment Method / Mode	Total Dental, Vision & Hearing Premium
Coverage Type	EFT - Monthly	\$0.00
Individual	Maximum Benefit \$5,000	

Select one of the following options:

Deductible Amount	Premium Amount with Incremental Preventive Services Coverage (60% yr. 1; 70% yr. 2; 80% yr. 3; 90% yrs. 4+)	Premium Amount with Full Preventive Services Coverage (100% all yrs.)
\$100	<input type="checkbox"/> \$39.15	<input type="checkbox"/> \$41.53
\$50	<input type="checkbox"/> \$44.62	<input type="checkbox"/> \$47.69
\$0	<input type="checkbox"/> \$50.51	<input type="checkbox"/> \$54.37
\$100 Disappearing	<input type="checkbox"/> \$47.92	<input type="checkbox"/> \$51.12

3

4 [View Blank Application](#)
[Flexible Choice Dental, Vision & Hearing Brochure](#)
[Flexible Choice Dental, Vision & Hearing Flyer](#)
[Flexible Choice Dental, Vision & Hearing Provider Link](#)

5 [START APPLICATION >](#)



Applicant Information

Cigna | EXPRESS APP ROCK ISLAND, IL


Getting Started

Applicant Information

End Application

Disposition and Notes

Applicant Information


 Use the Send Forms button above to email your customer a personalized link to this in-progress dental application if they prefer to complete it without assistance.

Applicant 1

First Name *	MI	Last Name *
<input type="text" value="HOLLY"/>	<input type="text"/>	<input type="text" value="WOOD"/>
Date of Birth *	Age	Gender *
<input type="text" value="10/15/1955"/>	<input type="text" value="66"/>	<input type="text" value="Female"/>
Phone *	Email Address *	<input type="checkbox"/> Applicant declined to provide email
<input type="text"/>	<input type="text"/>	
Resident Street Address (no PO Box) *	Apt/Suite/Other (Optional)	
<input type="text"/>	<input type="text"/>	
City *	State *	ZIP *
<input type="text" value="ROCK ISLAND"/>	<input type="text" value="IL"/>	<input type="text" value="61201"/>

Is your mailing address the same as your residential address? *

Yes No



Prior or Other Coverage

Cigna | EXPRESS APP ROCK ISLAND, IL

Getting Started

Applicant Information ✓

Dental Vision and Hearing (HOLLY) \$40.11

Prior or Other Coverage

Billing Information


HIPAA and Marketing Authorization

Final Steps

End Application

Disposition and Notes

Prior or Other Coverage

 Use the Send Forms button above to email your customer a personalized link to this in-progress dental application if they prefer to complete it without assistance.

Applicant 1

Does the applicant have other existing or pending dental insurance?

Yes No

Name of Company

Policy Number

1


If you have existing dental coverage that meets our requirements we will waive the class 3 waiting period.

Is the Insurance applied for here intended to replace any existing or pending dental insurance?

Yes No

Is any Applicant eligible for Medicare?

Yes No



Billing Information

Billing Information

Each policy is an individual contract and Third party/Company checks/payments premium, unless from an immediate family member or the payer is a Group/Ass been submitted and approved for the billing process.

Please make sure you inform your customer that they will be drafted upon policy issue.

Payor is other than Insured

Yes No

Account Information

Routing Number

Financial Institution

Account Type Account Number

Please Select

Bank Consent Verification Questions
(To be completed by Bank Account Owner/Depositor)

1. If bank draft, are you a named owner of the bank account from which funds are to be drafted?

Yes No

2. Are we authorized to draft your premium from your bank using the information provided above?

Yes No

SAVE

HIPAA and Marketing Authorization

Marketing Authorization

I grant my authorization to receive information or presentation of materials describing other insurance products.

Yes No

HIPAA Authorization

NOTE: Please read the acknowledgement statement below to your applicant.

AUTHORIZATION FORM FOR DISCLOSURE OF AN APPLICANT'S PROTECTED HEALTH INFORMATION

I hereby authorize the disclosure of protected health information about me as described below.

- The Company, as used in this authorization, shall mean American Retirement Life Insurance Company, Loyal American Life Insurance Company®, Cigna Health and Life Insurance Company, Cigna National Health Insurance Company, and their affiliates as described below.
- I authorize any licensed physician, medical practitioner, hospital, clinic, Pharmacy Benefit Manager, or other medical or medically-related facility, the U. S. Veterans Administration and Selective Service System, insurance company, MIB, Inc., or any other organization, institution, or person that has any records or information available as to the diagnosis, treatment, and prognosis with respect to any physical or mental condition and/or treatment relating to me or my family to disclose to the Company's underwriting, new business, claims, sales agents, and premium accounting representatives any such records or information. However, MIB, Inc., information will only be shared with the Company's underwriting staff and Medical Director.
- I authorize the Company to make a brief report of my protected health information to MIB, Inc.
- The protected health information described above will be disclosed to the Company to determine my or my family's eligibility to obtain coverage under the policy for which I/we have applied, and to determine the rates and terms which apply to the policy.
- This medical or health information includes information on the diagnosis and treatment of mental illness, alcohol, and drug use. This also includes information on the diagnosis, treatment, and testing results related to HIV, AIDS, and sexually-transmitted diseases unless otherwise restricted by state law.
- I understand that I may revoke this authorization in writing at any time, except to the extent that action has been taken by the Company in reliance on this authorization, by sending a written revocation to the Company's Privacy Office at PO Box 5700, Scranton, PA 18505-5700.
- I understand that the information which will be provided under this authorization is necessary for the Company to determine my eligibility for coverage under the policy and that the Company will condition its approval and issuance of the policy on my providing this authorization, and my application may be denied if I refuse to provide this authorization.
- I understand that if the person or entity that receives my protected health information is not a health care provider or health plan covered by the federal privacy regulations, the information may be re-disclosed by such person or entity and will likely no longer be protected by the federal privacy regulations.
- I understand that a photocopy, facsimile copy, or other electronic copy of this authorization shall be considered as effective and valid as the original. I also understand that I or my personal representative am entitled to receive a copy of this authorization upon request. This authorization will expire twenty-four (24) months from the date it is signed.
- If you are the representative of an Applicant, describe the scope of your authority to act on the Applicant's behalf:

The Personal Representative fields below are OPTIONAL unless a person authorized (under State or other applicable law, e.g., tribal or military law) is acting on behalf of the individual in making health care related decisions.

Personal Representative

Name

Relationship

SAVE NEXT

Final Steps

Cigna | EXPRESS APP ROCK ISLAND, IL

Getting Started

- Applicant Information ✓
- Dental Vision and Hearing (HOLLY) \$41.52
- Prior or Other Coverage ✓
- Billing Information ✓
- HIPAA and Marketing Authorization ✓
- Final Steps**
- End Application
- Disposition and Notes

Final Steps

Please use the Send Forms button above to send required Pre-Sale documents (Application Packet, Customer Booklet, Proposals (As Applicable)).

Product: Dental Vision and Hearing

Agent Acceptance

Effective Start Date
05/01/2022

Applicant Social Security No.

1. Have you been provided a blank copy of the application packet with any state specific disclosures, including HIPAA, Outline of Coverage and, if eligible for Medicare, a "Guide to Health Insurance for People with Medicare"?

Yes No

2. Do you attest that the information you provided on the application is accurate, complete and true?

Yes No

3. I understand that I have applied electronically for insurance and that by providing an answer to the security question and security pin number, this will be considered an effective and binding signature.

Yes No

Customer Verification

i Applicant Electronic Signature
The purpose of the below questions is to capture the applicant electronic signature. The applicant needs to remember the answers to the below questions in case the application needs to be verified.

Individual Whole Life



Policy Selection

▶ Cancer - Lump Sum
Policy Selection
Initial premium \$54.86

▶ Heart - Lump Sum

Individual Whole Life
Insured by Loyal American Life Insurance Company

	Payment Mode/Method	Total Base Premium
	EFT - Monthly	\$54.86
<small>Please select tobacco only if applicant has used tobacco/nicotine in the past 12 months.</small>		
Applicant 1 Coverage Type:		
1	<input type="text" value="Level Benefit Plan: NON-TOBACCO"/>	\$24.39
	Benefit Amount	
	<input type="text" value="\$5,000"/>	
Applicant 2 Coverage Type:		
	<input type="text" value="Level Benefit Plan: NON-TOBACCO"/>	\$30.47
	Benefit Amount	
	<input type="text" value="\$5,000"/>	
<small>The Level Benefit Plan includes the Terminal Illness Accelerated Benefit Rider</small>		
Optional Accidental Death Benefit to Age 100 Rider<(for an additional premium):		
2	<input type="checkbox"/> Applicant 1	\$0.00
	Benefit Amount	
	<input type="text" value="\$10,000"/>	
	<input type="checkbox"/> Applicant 2	\$0.00
	Benefit Amount	
	<input type="text" value="\$10,000"/>	
<small>Automatic Premium Loan (APL) Provision* (if no Option(s) selected, will default to "No")</small>		
3	<small>*Under this provision, any Premium becoming due and remaining unpaid at the end of its Grace Period will automatically be paid. The Premium will be charged as a loan against this Policy.</small>	
	Applicant 1	
	<input type="radio"/> Yes <input type="radio"/> No	
	Applicant 2	
	<input type="radio"/> Yes <input type="radio"/> No	
4	Are you AML certified?	
	<input type="radio"/> Yes <input type="radio"/> No	
	<small>You must be AML certified prior to submitting Whole Life. Please go to http://www.LIMRA.com to complete the required course.</small>	
	View Blank Application Individual Whole Life Brochure Individual Whole Life Brochure (Spanish)	



Beneficiaries

Beneficiaries

Please provide beneficiary information for the Applicant and Spouse/Domestic or Civil Union Partner if applicable.



If multiple beneficiaries are requested, please have the customer call 1-866-459-4272 (Option 3) once the policy is issued.

Applicant Name

Name of Beneficiary/Estate

Date of Birth/Estate Start Date

Relationship to Applicant

Primary or Contingent

Percentage of Benefit

Address

Social Security No. (if known)

1

Replacement

Replacement

1

Does the Applicant have existing individual life insurance policies or individual annuity contracts with this or any other company?

Yes No

2

If YES, (a) the Applicant and Agent must complete the required "Important Notice: Replacement of Life Insurance or Annuities" form; (b) the Agent must complete the "Agent Provided Sales Material Statement" below and sign; and (c) provide the following information (use additional sheet, if needed):

Insurance Company Name and Address	Contract or Policy Number	Is Coverage being Replaced?	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="text"/>	<input type="text"/>		
Insurance Company Name and Address	Contract or Policy Number	Is Coverage being Replaced?	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="text"/>	<input type="text"/>		

AGENT PROVIDED SALES MATERIAL STATEMENT

(MUST BE COMPLETED BY THE AGENT ONLY IF THE APPLICANT IS REPLACING EXISTING LIFE INSURANCE OR ANNUITY)

I hereby certify that in connection with my presentation to the Applicant herein, I only used sales material that was previously approved by Loyal American Life Insurance Company and that I left with or provided to the Applicant/Spouse/Domestic or Civil Union Partner a copy of the sales material used in my presentation to the Applicant.

Health History Information – Physician Information

Whole Life Health History Information

Applicant's Primary Physician

Name

Phone

Address

Health History Information – Disclaimer

Disqualification Questions



If you answer YES to any questions in (1-7), STOP - you are not eligible for coverage. IF you answered NO to questions (1-7), continue to questions (8-11).

Health History Information – Questions 1-7

1

Has any Applicant been diagnosed or treated by a member of the medical profession as having diabetes which was diagnosed prior to the age of 30 or diabetes requiring more than 50 units of insulin to control, or suffered complications from diabetes such as diabetic coma, insulin shock, or diabetic neuropathy?

Yes No

Within the past two (2) years, has any Applicant been diagnosed or treated by a member of the medical profession for any of the following: (a) Emphysema, Chronic Obstructive Pulmonary Disease (COPD), or chronic bronchitis; (b) stroke or Transient Ischemic Attack (TIA); (c) kidney disease other than kidney infection or kidney stones; (d) Multiple Sclerosis or Parkinson's Disease?

Yes No

Within the past four (4) years, has any Applicant been diagnosed or treated by a member of the medical profession for cancer (except basal cell carcinoma)?

Yes No

Within the past year, has any Applicant been treated, counseled, or been recommended to seek treatment for alcoholism, alcohol abuse, or any drug or substance abuse?

Yes No

Within the past two (2) years, has any Applicant been diagnosed or treated by a member of the medical profession for congestive heart failure, unresolved aneurysm, any respiratory condition requiring the use of oxygen, any kidney disease requiring dialysis, chronic hepatitis, cirrhosis, other liver disease, or chronic pancreatitis?

Yes No

Has any Applicant ever been diagnosed as having or treated by a member of the medical profession for Alzheimer's disease or dementia?

Yes No

In the past twelve (12) months, has any Applicant been diagnosed or treated by a member of the medical profession for cancer (except basal cell carcinoma) or has any Applicant ever had a recurrence of or metastasis of cancer (except basal cell carcinoma)?

Yes No

Field Declined: A "yes" answer on this question has caused a field decline. In order to move forward with other insurable applicants, please go back to the Product Selection screen and start a new application.

Health History Information – Questions 8-11



A "yes" answer to questions (8-11) will qualify your customer for Modified once you hit "next" to move forward. Please make sure to confirm the premium from the navigation bar with your customer prior to submitting.

Has any Applicant been diagnosed or treated by a member of the medical profession as having diabetes which was diagnosed prior to the age of 30 or diabetes requiring more than 50 units of insulin to control, or suffered complications from diabetes such as diabetic coma, insulin shock, or diabetic neuropathy?

Yes No

Within the past two (2) years, has any Applicant been diagnosed or treated by a member of the medical profession for any of the following: (a) Emphysema, Chronic Obstructive Pulmonary Disease (COPD), or chronic bronchitis; (b) stroke or Transient Ischemic Attack (TIA); (c) kidney disease other than kidney infection or kidney stones; (d) Multiple Sclerosis or Parkinson's Disease?

Yes No

Within the past four (4) years, has any Applicant been diagnosed or treated by a member of the medical profession for cancer (except basal cell carcinoma)?

Yes No

Within the past year, has any Applicant been treated, counseled, or been recommended to seek treatment for alcoholism, alcohol abuse, or any drug or substance abuse?

Yes No

1

Notice and Customer Information Form

Notice and Customer Information Form

To help the government fight the funding of terrorism and money laundering activities, Federal law requires us to obtain all relevant customer-related information necessary to run an effective anti-money laundering program.

What this means to you: When submitting an application/order ticket/request form, we ask that the producer obtain the client's name, street address, date of birth, tax identification number, and other customer-related information that will allow us to identify the customer and fulfill our obligations under Federal law. Picture documentation, such as a driver's license or other identifying documents, will be used to verify the information given at the time of the sale.

By acknowledging receipt of this Notice and Customer Information Form, the undersigned authorizes any law enforcement agency, public or private institution, information service bureau, or other entity contacted by the Company identified above to furnish information sufficient to confirm the personal information of the undersigned as required by Federal law. This information is confidential and will not be used for any other purpose. The undersigned hereby releases all persons, agents and agencies, and entities providing confirming information from any and all liability arising out of the request for or the release of confirming information.

The owner information section must be completed in its entirety. If identification documents are not available, the customer must sign the form and the information will be verified by the Company.

The following information must be obtained for each tax identification number or social security number disclosed on the application for insurance.

Notice and Customer Information Form

1

Owner

FEIN / SSN # Owner Name Date of Birth

Occupation Employer

ID Type

Driver's License/State ID
 Other Passport
 Owner is an entity; legal document(s) attached (e.g., Articles of Incorporation, Trust Agreements, etc.)

Other Details

State / Country Number Date Issued Exp. Date

The source of funds for this transaction is:

The purpose of this transaction is:

Agent: I have examined and verified the customer's ID as noted above is true and correct to the best of my knowledge and belief.

Additional Information

Resume/delete an incomplete quote or application

Cigna | EXPRESS APP Send Forms Welcome, TRUMP ONE MICHAEL LB

Broker Campaigns: HOST Create Self-Enroll Link

START A NEW QUOTE

Zip Code
77494 TX

Date of Birth
09/06/1954

Age
69

Gender
Male

Child Only Dental Application

QUICK QUOTE/APPLY

Use eSignature for faster signing and quote issuance processing

Inbound Voice Signatures now available for your business

cigna healthcare

QUOTE/APPLICATION DETAILS X

02/15/1957 2024-03-25 Quote test agent I

Female
123 TEST ST WEST CHESTER, PA 19380
JESSICA.ALTER@CIGNAHEALTHCARE.COM
Home: 559-123-5469
Application Id: EXOOOGE9T

Medicare Supplement (TEST): NOT SUBMITTED
 Medicare Supplement (DEMONSTRATIONTEST CSBTSTDEMO): SUBMITTED

Resume
View PDF
Delete Lead

*For agent use only

Show Deleted Leads


↻
📅
☰

DATE	STATUS	LAST NAME	FIRST NAME	PHONE NUMBER	DATE OF BIRTH	ZIP CODE	STATE
2024-04-11	0 of 2 Submitted	HGGJ	JJHG	565-646-6546	1950-01-01	75001	TX
2024-04-11	0 of 2 Submitted	GJG	JHGJ	324-242-4232	1950-01-01	75001	TX
2024-04-11	0 of 2 Submitted	ASD	ASDAD	123-123-1231	1950-01-01	75001	TX
2024-04-11	0 of 2 Submitted	ASDSAD	ASDASD	213-123-1231	1950-01-10	75001	TX
2024-04-11	0 of 2 Submitted	ASDASD	DASD	123-123-1232	1950-01-01	75001	TX



Application confirmation

Agent email confirmation



WELCOME
to the family

Dear agent name,
Thank you for your recent application for Cigna Medicare Supplement.
You can view your customer's application on [Producer Portal](#) in the 'My Messages' section.

You are required to provide your customers with the following materials upon completion of the application:

1. An Outline of Coverage (if applicable, per product) and other required forms
2. If eligible for Medicare, "[A Guide to Health Insurance for People with Medicare](#)"

We will confirm the applicant received these materials during the Phone Verification (PV) interview, if applicable.

If a PV interview is required and your customer has not already completed the PV, please have them call 866.825.4822 at their earliest convenience. The PV hotline is available 24 hours a day, seven days a week. When applicable, a PV must be completed in order to finish the application process. [Click here](#) to learn more about our PV requirements.


In doing business with us, you can expect:

- Fast, new business processing
- Prompt claim payments
- Timely commission payments |
- Online forms, policy information and more via [Producer Portal](#)
- Financial Stability

If you have any questions about your customer's submitted application, please log on to [Producer Portal](#), or contact our New Business Department at 877.454.0923.

You will receive an email for each application you submitted for your customer.

Applicant email confirmation



WELCOME
to the family

Dear Inez Kennedy,

Thank you for your recent application for Medicare Supplement. We have attached a copy of your application and encourage you to review it for accuracy. For your convenience, we have also included an Outline of Coverage (if applicable, per product) and other required documents along with *Choosing A Medigap Policy: A Guide to Health Insurance for People with Medicare*, in case you are eligible for Medicare.

First, please review the consent acknowledgement below.

View Disclosures

By accessing and opening the documents sent to you via the e-mail address that you have provided to us, you certify that: You (i) consent and agree to receive disclosures, documents and notices electronically and confirm that you will download or print them for your records, (ii) acknowledge that you have the ability to access the information that is provided electronically via email communications, and (iii) acknowledge that such action constitutes your agreement and consent to receive electronic communications on a single use basis throughout the insurance purchasing process [i.e., from receipt of a proposal, completion of an application and continuing for thirty (30) days after you receive an issued policy sent to you through normal U.S. mail.]

A Guide to Health Insurance for People with Medicare

The attached application is password protected to safeguard your privacy. To view the application, please enter your date of birth in the format below along with the last four digits of your Social Security Number (SSN).

MMDDYYYY

For example: If your date of birth is April 2, 1943 and the last four digits of your SSN are 1234, you would enter the following password when prompted.

040219431234

NOTE: You do not need to use dashes or slashes.

If you have not completed a Phone Verification (PV) for Medicare Supplement, please call **866.825.4822** at your earliest

Medicare supplement rates

Rate classes

- Quotes will be displayed for all available rate-classes on the Policy Selection page
- Medical Questions will appear within the application as necessary based on the applicants answer to OE/GI questions, DOB, and Part B effective date

Tobacco question

- The tobacco question appears in the application, either in Applicant Info or Medical questions, depending on the state
- The rate class will adjust as necessary based on applicants answer to tobacco question
- Any necessary updates, based on the applicants answers, will appear on the Review Plan screen

OE / GI / UW

- The applicant rate class will dynamically adjust during the application process, based on applicants answers to:
- DOB, Part B effective date, OE/GI determination questions, Questions about current or previous medical coverage

Review Plan Selection

Review Plan Selection

- New addition to allow for review of the plan selection at various points in the application process
- Based on the applicants answers to the OE, GI and Tobacco questions, new plan selection/premium rates may be required or advised
- This page gives the ability for the agent to make necessary changes to Plan selection (within the same Charter), HHD selection, billing mode, etc.

Multiple Applicants

Multiple applicants

- Applicant 1 and Applicant 2 will appear stacked on Navigation Bar
- Navigation Bar allows agent to follow along the app pages for each Applicant consecutively, as well as skip back and forth between different sections of multiple applicant pages if necessary
- Agent will be able to Submit each application separately. The agent will need to click “Submit” for each application being submitted.
- Applicant 1 and Applicant 2 (etc.) can quote and apply for varying multiple products and situations, consecutively
 - i.e. – Applicant 1 can apply for Plan F Guarantee Issue on CHLIC and Applicant 2 can apply for Underwritten Standard II Plan G on ARLIC, consecutively during the same application process. These applications will be stacked in the Navigation Bar as the agent goes through the tool
- Multiple payment methods and modes for multiple applicants and products can be selected (Medicare Supplement)

Changing an application in process

Changes during the application process

- To Change Medicare Supplement Charter while in an application, Add and Remove Benefits, Add or Change Supplemental Health Riders, or Add Applicants to saved prospects and in-process applications, the agent can click on the saved Prospect from the Home page (by clicking on the blue Express App link while in an application)
- This will take the agent back to the Policy Selection screen, where they can update the Policy and Plan selections for the application/s they are completing
- After updating, the agent should click “start application” to take them back in to the application. The updates to Policy Selection will apply.
- The agent will need to click ‘Next’ on each page to reconfirm any saved information.

FAQ

Express App 2.0



Accessing the tool, prospects, and starting a quote

Q: How to access Express App 2.0?

- ❖ Log in to Producer Portal @ Cignaforbrokers.com and select quote and enroll

Q: How can the agent find the applications they submitted through Express App 2.0?

- ❖ Submitted applications can be accessed in *Producer Portal ->My Messages*

Q: How does 'Send Forms' work in Express App 2.0?

- ❖ The agent will be able to email the Required Forms (and Proposals, if available) via Send Forms, to the customer at any time during the quoting and applying process.

Accessing the tool, prospects, and starting a quote

Q: How can the agent access their prospects, incomplete applications and incomplete quotes?

- ❖ All of the agents "prospects" are saved and viewable on the Home Page. The agent will be able to click on the prospect to resume incomplete applications. The agent is also able to sort their prospects on the Home Page. All information entered on an incomplete application will be auto-saved after the agent hits the "Next" button. There is also a "Save" button the agent can click before exiting.

Q: How long will Prospects be saved in Express App 2.0?

- ❖ Prospects will be stored 90 days

Q: Will Express App 2.0 be able to quote Under 65 Med Supp customers?

- ❖ No. The tool will advise the agent that the product is not available. Agent will need to quote manually from rate sheets in Agent View and submit via paper app.

Multiple applicants

Q: Do couples have to be in the same situation (i.e. both OE or both GI) to apply at the same time?

- ❖ No. Applicant 1 and Applicant 2 (etc.) can quote and apply for varying multiple products and situations during the same quoting/applying process.
 - ❖ i.e. – Applicant 1 can apply for Plan G Guarantee Issue on CHLIC and Applicant 2 can apply for Underwritten Standard II Plan G on ARLIC, during the same quoting/applying process.
 - ❖ i.e. – Applicant 1 can apply for Plan G Open Enrollment on CHLIC and both Applicant 1 and Applicant 2 can apply for a Couple Ancillary plan during the same quoting/applying process.
 - ❖ Multiple payment methods, modes and multiple effective dates for multiple applicants and products can be selected.
 - ❖ Multiple products and applicants' applications will be stacked in the Navigation Bar
 - ❖ The Agent will be able to Submit each application completed as a separate application (will click “submit” for each application)

Q: How does the agent quote multiple applicants?

- ❖ Use the Applicant boxes on the right-hand side of the Policy Selection screen to enter in additional applicant information for the quote
- ❖ Multiple products and applicants' applications will be stacked in the Navigation Bar
- ❖ Dependent information will be asked on the Applicant Info tab.

Guarantee Issue and Open Enrollment

Q: Will Medical Questions appear in Express App 2.0 if the applicant is in an OE or GI?

- ❖ No, Medical Questions will only appear if it is an Underwritten application.

Q: Will the agent need to click on an OE, GI, or UW button to let the tool know what type of application it is?

- ❖ No. The applicant enrollment type and rate class will dynamically adjust during the application process, based on applicants answers to DOB, Part B effective date, OE/GI determination questions, and Questions about current or previous medical coverage.

Q: Will the agent be able to see the different state specific GI scenarios for that state?

- ❖ Yes. Specific State specific scenarios have been built in to the tool and will appear in the Guarantee Issue scenario selection screen.

Q: Will the agent be able to upload GI proof in Express App 2.0?

- ❖ Yes, using the Document Upload feature on the Review and Accept page. Based on the answers on the application agents will be prompted to upload documentation for GI or POA.
- ❖ You can also use the Document Upload feature to respond to RFIs and upload documentation on AgentView.

Making changes to an in-progress application

Q: How do I change the Part B effective date, RX info, prior carrier info, or other info (not dob, zip, gender)?

- ❖ Use the navigation bar to go to the page that needs to be updated. Click on “Change answers”. This will open up the fields to be updated.
- ❖ **Do not use back button on browser.**

Q: How do I change the Charter selection, Date of Birth, Zip Code, or Gender of the applicant, prior to the application being submitted?

- ❖ For changes to Charter, dob, zip, or gender – for all application types – the agent will need to start a new quote by clicking on Express App logo on top left of screen. This info can only be updated on the Start A New Quote box.

Q: How do I change the Medicare Supplement Plan selection, Billing Info or add the LWS/HHD prior to the application being submitted?

- ❖ The agent can update billing mode, add or deselect LWS/HHD, and change Plan selection (within same charter), on the **Review Plan Selection page**.

Completing an application

Q: How do I update the customers billing mode during a Medicare Supplement application?

- ❖ The agent can update a billing mode on the Review Plan Selection page for that application.
- ❖ For Supplemental Health applications, the agent will need to click on the blue Express App link and return to the Quote Screen to update and start a new application.

Q: Does Express App 2.0 'Auto-Save'?

- ❖ Yes. The tool will auto-save any page that has been completed after hitting "Next". Prospects can be accessed on the Home Page. To save an incomplete page before exiting, click "Save".

Q: Will the agent need to enter a social security number and also a Medicare Card number?

- ❖ Medicare supplement applications require a Medicare number and, where required by the state, a Social Security number.

Completing an application

Q: On HIPAA and Marketing HIPPA forms, is the Personal Representative field required?

- ❖ No, it is not required. In addition, we have added a tool-tip to explain what a personal representative is.

Q: How do I make a correction on a submitted application after it has been received by New Business?

- ❖ Through the New Business RFI process.

Q: Will the agent need to “Verify” each page of the application?

- ❖ The agent will need to click “next” to move on to the next page.
- ❖ The tool will not allow the agent to click “Submit” without all required fields and pages being completed.

Q: What if the customer does not have an email address to enter on the application?

- ❖ Customers can apply in Express App 2.0 without having an email address. The agent will need to ensure they are supplying their customer with any required documents via postal mail or another alternative to email.

Completing an application

Q: Will the customer need to complete a Phone Verification?

- ❖ Yes, as applicable. Current business rules to Phone Verifications are still in place. In addition, Express App 2.0 will provide the Phone Verification phone number at the end of the application process, when applicable.

Q: How does an agent submit the customers application in Express App 2.0?

- ❖ On the Review and Accept page – agent will click “Submit”
- ❖ The agent can only access the “Submit” button if EVERYTHING required on the app has been completed.
- ❖ Agent will need to click “Submit” for **each** application they are completing.
- ❖ If a customer does not want to continue with an application, return to the home page and do not submit the application.

Q: After submitting an application, how long until the confirmation email is sent?

- ❖ Confirmation emails will be sent for submitted applications, every 15 minutes, 24/7/365.
- ❖ The agent should expect one confirmation email per application submitted.

The Incentives



Wincentives 2024

Rewards to take your business to the next level

See CignaforBrokers.com for full rules and details.

1,000

targeted leads with a direct mail campaign for every fourth application you write each month for underwritten Medicare Supplement plans F, G, N and Open Enrollment Plan N.

Eligible in AK, AL, AR, AZ, CA, CO, CT, DE, FL, GA, HI, IA, ID, IL, IN, KY, LA, MD, ME, MI, MO, MS, NC, NE, NH, NJ, NM, NV, OH, OK, OR, PA, RI, SC, SD, TN, TX, UT, VA, VT, WI, WV and WY. From January 1, 2024 to December 31, 2024.

\$100

Bonus for every underwritten Medicare Supplement Plans F, G, N and Open Enrollment Plan N application you write each month.

Eligible in AK, AL, AR, AZ, CT, DE, FL, GA, HI, IA, ID, IL, KS, KY, LA, MD, MS, NC, NE, NH, NJ, NM, NV, OH, OK, PA, SD, TX, UT, VA, VT and WY. Minimum of four applications. Incentives retroact to first application. From January 1, 2024 to December 31, 2024.

\$25

Bonus for every application you write each month for Accident Treatment, Cancer Treatment, Choice Accident, Flexible Choice Cancer and Heart Attack & Stroke, and Flexible Choice Hospital Indemnity.

Eligible in all states where product is sold. Minimum of five applications. Incentives retroact to first application. From January 1, 2024 to December 31, 2024.

\$25

Bonus for every application you write each month for Flexible Choice Dental, Vision & Hearing application.

Eligible in all states where product is sold. Minimum of five applications. Incentives retroact to first application. From January 1, 2024 to December 31, 2024.

Cigna Supplemental Benefits Product Portfolio



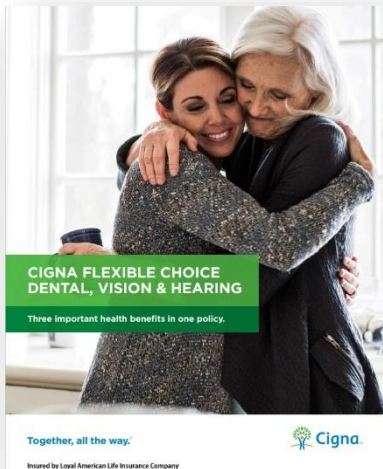
Medicare Supplement

For customers who are enrolled in Medicare Parts A & B, we offer Medicare Supplement coverage to help pay out-of-pocket expenses plus value added service programs.



Flexible Choice Dental, Vision & Hearing

Covers care that goes above and beyond routine check-ups and protects you from high out-of-pocket costs.



Flexible Choice Cancer and Heart Attack & Stroke

Provide lump-sum benefits for diagnosis of cancer and/or heart conditions and stroke with the flexibility to add multiple riders for recurrence, restoration, specified disease, accidents and more.



Flexible Choice Hospital Indemnity

Indemnity benefits to help pay for a broad range of hospital expenses.



Access the Cigna Supplemental Product Portfolio with additional details [here](#)

Cigna Supplemental Benefits Product Portfolio



Cancer Treatment

Indemnity benefits to help pay for a broad range of cancer treatments, care and associated costs.



Accident Treatment

Indemnity benefits to help pay for a broad range of treatments when injured in a covered accident.



Individual Whole Life

Designed to help pay final expenses with Level and Modified benefits to provide coverage under a variety of health conditions.



Choice Accident

Indemnity benefits to help pay for a broad range of treatments when injured in a covered accident with options to cover parents and disabilities incurred from the injury.



Access the Cigna Supplemental Product Portfolio with additional details [here](#)

Contact List

Cigna Supplemental Benefits

Contact	Phone	Fax	Email
Agent Resource Center	877.454.0923		CSBNewBusiness@Cigna.com
Phone Verification (PV) hotline	866.825.4822		CSBNewBusiness@Cigna.com
All claims	866.459.1755	512.531.1480	
New business	877.454.0923	888.695.2591	CSBNewBusiness@Cigna.com
Underwriting	877.454.0923		CSBNewBusiness@Cigna.com
Commissions	877.454.0923	512.590.6045	CSBCommissions@Cignahealthcare.com
Agent Contracting	877.454.0923	888.832.4154	CSBLicensing@Cignahealthcare.com
Website login assistance	877.454.0923		CSBNewBusiness@Cigna.com
Product availability	877.454.0923		CSBAgentMarketing@Cigna.com
Customer services	877.454.0923	888.670.0146	CSBSupport@Cigna.com
FaxApp submission		877.704.8186	
Premium accounting		888.670.0146	CSBPremiumReferrals@Cigna.com
Supplies			Refer to Cigna for Brokers to order.

Addresses

Mailed Applications
Cigna Supplemental Benefits
PO Box 5725
Scranton, PA 18505-5725

Overnight and Express Mail
Cigna Supplemental Benefits
11501 Alterra Parkway
Austin, TX 78758

Customer Services
PO Box 5700
Scranton, PA 18505-5700



**Thank you for your
partnership!**

