Allegiance℠ by Cigna Healthcare

DEBIT CARD ENROLLMENT FORM

Personal Information

Employer:			
Name:		SSN:	
Address:	City:	State:	Zip:
Birth Date: ☐ Male ☐ Female		☐ Married	☐ Single
Email Address:			

Cardholder Use Acknowledgement

1. I may only use the card to pay for eligible medical expenses.
2. I may not use the card for expenses already reimbursed.
3. I may not seek reimbursement under any other health plan for expenses paid with the card.
4. I will acquire and provide documentation for expenses paid with the card.
5. I have been provided an explanation of the fees associated with the debit card.

Employee Signature: ______________________ Date: ______________________

As a security measure your card will be mailed in a plain white envelope.
Please be careful not to throw it away with the junk mail!