Government of Guam
Enrollment/Change of Status Form

EMPLOYMENT STATUS:	☐ Active Employee	☐ Retiree ☐ Survivor of Retiree	☐DB Retirement Fund ☐DC Retirement Fund

GOVGUAM AGENCY/DEPARTMENT	DATE OF EMPLOYMENT	EFFECTIVE DATE

EMPLOYEE/RETIREE INFORMATION

Last Name		First Name		M.I.
Social Security Number		Date of Birth	Sex	Marital Status
Mailing Address				
Home Phone	Work Phone (Include Ext)	Cell Phone	Email Address	

☐ **CHANGE OF STATUS** - I am a current member and I would like to make a change to my policy

- ☐ Add Dependent - List dependent to be added and attach any supporting documents.
- ☐ Delete Dependent - List dependent below to be deleted.
- ☐ Class Change - Indicate your new Class Option and attach any supporting documents.
- ☐ Coverage Change - Indicate your new medical or dental election (only during Open Enrollment).
- ☐ Update Information - Indicate new information such as address or telephone changes.
- ☐ Name Change - Indicate your new name and attach supporting documents.
- ☐ Terminate Coverage - Applicable only during Open Enrollment or upon employment termination.

☐ **NEW ENROLLMENT** - I am a new member (Please indicate your medical & dental option)

PLAN ELECTION

MEDICAL ELECTION

☐ **HSA2000** Single $2,000 deductible / Family $4,000 deductible

Do you want to participate in a Health Savings Account (HSA)?

☐ Yes ☐ No If yes, complete the HSA Election below

☐ **PPO1500** Single $1,500 deductible / Family $3,000 deductible

DENTAL ELECTION

☐ **Yes**, I want dental coverage ☐ **No**, I do not want dental coverage

OTHER INSURANCE - I have or my dependents have or will have health coverage with another carrier

Name of Insured	Insurance Carrier	Medicare	Effective Date
		☐ Part A ☐ Part B ☐ Part D	
		☐ Part A ☐ Part B ☐ Part D	

DEDUCTION CLASS

- ☐ Class I Employee/Retiree or Survivor Only
- ☐ Class II Employee/Retiree or Survivor with Spouse
- ☐ Class III Employee/Retiree or Survivor with Child/ren
- ☐ Class IV Employee/Retiree or Survivor with Spouse and Children

HEALTH SAVINGS ACCOUNT ELECTION (you are eligible only if enrolled in an HSA plan)

☐ I already have an HSA ☐I do not have an HSA and I want to participate

GYM PARTICIPATION ELECTION

☐ **Yes**, I want to enroll in a gym ☐ **No**, I do not want to enroll in a gym

If yes, a separate form must be completed for your gym election (Some gyms may have limited enrollment)

DEPENDENT INFORMATION (Spouse & dependent children up to 26 years of age)

Last Name	First Name	M.I.	Social Security No.	Sex	Birthdate	Relationship

I agree that I shall abide by the provisions of coverage in the policy under which I am enrolled. I have read and understand the eligibility requirements and attest that I and all dependents meet these requirements. I understand that it is my responsibility to report any changes in the eligibility of my dependents. I understand that newly eligible dependents, to include legal guardians, may only be added within 30 days from becoming eligible or during Open Enrollment period. I understand that NetCare Life & Health Insurance Co. has the right to request required documents at any time and failure to submit these documents may result in a loss of coverage or service at the discretion of NetCare Life & Health Insurance Co. Should this occur, I understand and agree I may be responsible for the cost of all health care provided to me and my dependents. I understand that the providing of coverage and service does not constitute acceptance of eligibility by NetCare Life & Health Insurance Co. until eligibility for coverage has been proven. I further understand that any claims asserted by myself or my dependents against NetCare Life & Health Insurance Co. or any provider, whether based in tort, contract or otherwise (including professional liability) are subject to binding arbitration. Fraud Warning Notice: Any person who, with intent to defraud or knowing that he she is facilitating a fraud against an insurer, submits a request for enrollment, or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Employee Signature **Date**