JUDICIARY OF GUAM
Enrollment/Change of Status Form

☐ New Enrollment ☐ Change of Status	EFFECTIVE DATE	EFFECTIVE PPE

DIVISION	DATE OF EMPLOYMENT

EMPLOYEE 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	

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

☐ **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.
- ☐ Update Information - Indicate new information such as address or telephone changes.
- ☐ 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).
- ☐ Terminate Coverage - Applicable only during Open Enrollment or upon employment termination.

PLAN ELECTION

MEDICAL ELECTION

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

☐ **PPO1000** Single $1,000 deductible / Family $2,000 deductible

DENTAL ELECTION

☐ **YES**, I want dental coverage ☐ **NO**, I do not want dental coverage

- ☐ **DENTAL 1000**
- ☐ **DENTAL 2000 with Orthodontia**

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 Only ☐ Class III Employee with Children

☐ Class II Employee with Spouse ☐ Class IV Employee with Spouse and Children

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**