

Enrollment /Change of Status Form

Enrollment		Change of Status							Cancellation/Termination							
 New Enrollment Special Enrollment 		□ Name □ Addre	□ PCP Change					 Terminate All Coverage Terminate Eligible Dependent(s) Terminate COBRA Delete Dental 								
	1	Open Epr	ollment or HIPAA (Qualifying Change:				· ·								
Complete S	ections A-F] Plan Change					Ter	Termination Reason/HIPAA Qualifying Event						
complete 5		Birth*	Add Medical Coverage				erage	□ Resignation/Termination □ Retirement								
		□ Adopt		Add Dental Coverage				-		Death	-] Divorce		
		□ Add D							Loss of Eligibility Reason:							
										□ Other:						
* Supporting Doc			ting Documents rec	ments required						\checkmark						
										Complete Sections B, C, F						
4			,					Are	Are you electing COBRA? (consult with your employer for COBRA eligibility)							
Complete S			ections A-F						□ Yes (a separate election form must be submitted) □ No							
							<u> </u>									
A. PLAN ELECTION Guam					CNMI					P	alau		Dental			
□ Platinum		Advantage POS			CNMI Preferred					Palau Prefer			Smile Dental			
□ Prime		□ Advantage HMO			CNMI Standard					🗆 Palau Prime				□ Brite Dental		
□ SmartCh	oice 1500	□ SimpliWell EPO			CNMI Prime					□ Other:				□ Other:		
□ SmartCh					CNMI Limited											
U Other:_			CNMI Limited 80/20 Other:													
						er:										
B. EMPLO	YEE Informatio	n (All field	ds must be complete	ed)												
Last Name					First Name									M.I.		
NetCare Me	ember #	Social Security #			Date of Birth					Gender □ Female □ Male				Marital Status		
Home Phon	e	Work Phone		Other Contact No)		Email Address						
Mailing Add	lress															
Employer					Occupation					Date of Hire				quested E	ffective Date	
C. FAMILY Information (All fields must be completed)													1			
Add / Terminate	' Last Name		First Name		M.I. (Gende	nder DOB		SSN / Citizenship		ationship to Subscriber		verage	Primary Care Physician (Required for Adv POS/HMO Plans)	
Add										SSN:	Subs	criber	□ Medica □ Dental			
Terminate Add										Citizenship: SSN:			Dental Medica			
Terminate										Citizenship:		Der				
□ Add □ Terminate										SSN: Citizenship:			□ Medica □ Dental			
□ Add □ Terminate	ate								SSN: Citizenship:		Me Der					
			- /- /													
D. OTHER	INSURANCE CO	OVERAGE	E (Other coverage	e inf	1			<i>ust be c</i> r Insurance	omp	pleted for subs	criber	and a	ll enroli	<i>Effective</i>	idents)	
La	ast Name	First Name			Cove					Medicare Coverage Policy		olicy Hold	der Name	Date	ID #	
				□ Yes						Part A						
				□ No □ Yes					art A 🗆 Part B 🗆 Part D							
				□ Tes					isability ESRD							
				□ Yes					Part A □ Part B □ Part D Disability □ ESRD							
				No Ves					Disability ESRD Part A Part B Part D							
									sability ESRD							
E. BENEFI	CIARY Informa	tion (Only	y if applicable to yo	ur p	lan)											
Beneficiary'	s Full Name	Relations				Relations	hip 1	hip to Subscriber			Date of Birth					
	WLEDGMENT	the provisio	ons of coverage in the	polic	v und	or wh	nich I	(we) are	onrol	lled Lunderstand	that it is		nonsihilit	v to report	any changes in the	
-		-	t any claims asserted by	-												
			ion liability) are subjec			•							•	•		
			hereby authorize my el Ince policy issued to the		-							-			-	
Notice: Any p	erson with intent to	defraud or	knowing that he/she is				•	•								
deceptive stat	tement is guilty of in		ıd.					-							_	
Employee Sigr	Date E				Employer Signature					Date						