NetCare
Life & Health Insurance

For NetCare Use
Member ID # _____
Effective Date _____

Enrollment /Change of Status Form

Enrollment	Change of Status	Cancellation/Termination
☐ New Enrollment ☐ Special Enrollment ↓ **Complete Sections A-F**	☐ Name Change* ☐ PCP Change ☐ Address Change Open Enrollment or HIPAA Qualifying Change: ☐ Marriage* ☐ Plan Change ☐ Birth* ☐ Add Medical Coverage ☐ Adoption* ☐ Add Dental Coverage ☐ Add Dependent ** Supporting Documents required* ↓ **Complete Sections A-F**	☐ Terminate All Coverage ☐ Terminate Eligible Dependent(s) ☐ Terminate COBRA ☐ Delete Dental Termination Reason/HIPAA Qualifying Event ☐ Resignation/ Termination ☐ Retirement ☐ Death ☐ Divorce ☐ Loss of Eligibility Reason: _____ ☐ Other: _____ ↓ **Complete Sections B, C, F** Are you electing COBRA? *(consult with your employer for COBRA eligibility)* ☐ Yes *(a separate election form must be submitted)* ☐ No

A. PLAN ELECTION

Guam	CNMI	Palau	Dental
☐ Platinum Preferred ☐ Advantage POS ☐ Prime ☐ Advantage HMO ☐ SmartChoice 1500 ☐ SimpliWell EPO ☐ SmartChoice 2500 ☐ Other: _____	☐ CNMI Preferred ☐ CNMI Standard ☐ CNMI Prime ☐ CNMI Limited ☐ CNMI Limited 80/20 ☐ Other: _____	☐ Palau Preferred ☐ Palau Prime ☐ Other: _____	☐ Smile Dental ☐ Brite Dental ☐ Other: _____

B. EMPLOYEE Information *(All fields must be completed)*

Last Name		First Name		M.I.
NetCare Member #	Social Security #	Date of Birth	Gender ☐ Female ☐ Male	Marital Status
Home Phone	Work Phone	Other Contact No	Email Address	
Mailing Address				
Employer		Occupation	Date of Hire	Requested Effective Date

C. FAMILY Information *(All fields must be completed)*

Add / Terminate	Last Name	First Name	M.I.	Gender	DOB	SSN / Citizenship	Relationship to Subscriber	Coverage	Primary Care Physician *(Required for Adv POS/HMO Plans)*
☐ Add ☐ Terminate						SSN: Citizenship:	*Subscriber*	☐ Medical ☐ Vision ☐ Dental	
☐ Add ☐ Terminate						SSN: Citizenship:		☐ Medical ☐ Vision ☐ Dental	
☐ Add ☐ Terminate						SSN: Citizenship:		☐ Medical ☐ Vision ☐ Dental	
☐ Add ☐ Terminate						SSN: Citizenship:		☐ Medical ☐ Vision ☐ Dental	

D. OTHER INSURANCE COVERAGE *(Other coverage information must be completed for subscriber and all enrolled dependents)*

Last Name	First Name	M.I.	Other Coverage	Other Insurance Carrier Name	Medicare Coverage	Policy Holder Name	Effective Date	ID #
			☐ Yes ☐ No		☐ Part A ☐ Part B ☐ Part D ☐ Disability ☐ ESRD			
			☐ Yes ☐ No		☐ Part A ☐ Part B ☐ Part D ☐ Disability ☐ ESRD			
			☐ Yes ☐ No		☐ Part A ☐ Part B ☐ Part D ☐ Disability ☐ ESRD			
			☐ Yes ☐ No		☐ Part A ☐ Part B ☐ Part D ☐ Disability ☐ ESRD			

E. BENEFICIARY Information *(Only if applicable to your plan)*

Beneficiary's Full Name	Relationship to Subscriber	Date of Birth

F. ACKNOWLEDGMENT

I agree that I (we) shall abide by the provisions of coverage in the policy under which I (we) are enrolled. I understand that it is my responsibility to report any changes in the eligibility of my dependents. I understand that any claims asserted by myself or my dependents against NetCare Life & Health Insurance company or any provider, whether based in tort, contract or otherwise (including profession liability) are subject to binding arbitration. I have read the benefit brochure and any questions pertaining to the NetCare Health Plan has been answered satisfactorily. I (we) hereby authorize my employer to deduct any required costs for the program from my wage. I have had the opportunity to review the group comprehensive medical expense insurance policy issued to the employer, and agree that I (we) will be bound by the terms and conditions therein contained. Fraud Warning Notice: Any person 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	Employer Signature	Date