

Enrollment /Change of Status Form

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

A. PLAN ELECTION			
Guam	CNMI	Palau	Dental
<input type="checkbox"/> Platinum Preferred <input type="checkbox"/> Prime <input type="checkbox"/> SmartChoice 1500 <input type="checkbox"/> SmartChoice 2500 <input type="checkbox"/> Other: _____	<input type="checkbox"/> Advantage POS <input type="checkbox"/> Advantage HMO <input type="checkbox"/> SimpliWell EPO	<input type="checkbox"/> CNMI Preferred <input type="checkbox"/> CNMI Standard <input type="checkbox"/> CNMI Prime <input type="checkbox"/> CNMI Limited <input type="checkbox"/> CNMI Limited 80/20 <input type="checkbox"/> Other: _____	<input type="checkbox"/> Palau Preferred <input type="checkbox"/> Palau Prime <input type="checkbox"/> Other: _____
			<input type="checkbox"/> Smile Dental <input type="checkbox"/> Brite Dental <input type="checkbox"/> Other: _____

B. EMPLOYEE Information (All fields must be completed)				
Last Name		First Name		M.I.
NetCare Member #	Social Security #	Date of Birth	Gender <input type="checkbox"/> Female <input type="checkbox"/> 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)
<input type="checkbox"/> Add <input type="checkbox"/> Terminate						SSN: Citizenship:	Subscriber	<input type="checkbox"/> Medical <input type="checkbox"/> Vision <input type="checkbox"/> Dental	
<input type="checkbox"/> Add <input type="checkbox"/> Terminate						SSN: Citizenship:		<input type="checkbox"/> Medical <input type="checkbox"/> Vision <input type="checkbox"/> Dental	
<input type="checkbox"/> Add <input type="checkbox"/> Terminate						SSN: Citizenship:		<input type="checkbox"/> Medical <input type="checkbox"/> Vision <input type="checkbox"/> Dental	
<input type="checkbox"/> Add <input type="checkbox"/> Terminate						SSN: Citizenship:		<input type="checkbox"/> Medical <input type="checkbox"/> Vision <input type="checkbox"/> 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 #	
			<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Part A <input type="checkbox"/> Part B <input type="checkbox"/> Part D <input type="checkbox"/> Disability <input type="checkbox"/> ESRD				
			<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Part A <input type="checkbox"/> Part B <input type="checkbox"/> Part D <input type="checkbox"/> Disability <input type="checkbox"/> ESRD				
			<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Part A <input type="checkbox"/> Part B <input type="checkbox"/> Part D <input type="checkbox"/> Disability <input type="checkbox"/> ESRD				
			<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Part A <input type="checkbox"/> Part B <input type="checkbox"/> Part D <input type="checkbox"/> Disability <input type="checkbox"/> 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