NetCare
Life & Health Insurance

☐ COMMERCIAL GROUP ENROLLMENT APPLICATION
☐ CHANGE OF STATUS FORM

For NetCare Use Only
ID#: _____
Eff. Date: _____

CHANGE OF STATUS

STATUS CHANGE ADDITIONS:
Date of Addition _____
☐ Birth * ☐ Add Dependent(s) *
☐ Adoption * ☐ Loss of Coverage *
☐ Marriage * ☐ Add Dental *
* Documentation required

STATUS CHANGE DELETIONS: Term Date: _____
☐ Cancel Eligible Dependent(s) ☐ Delete Dental (OE Only)
☐ Cancel all Coverage Does employee wish to continue under COBRA? ☐ Yes ☐ No

TERMINATION DUE TO:
☐ Employee Termination ☐ Spouse's Employment Change ☐ Retirement ☐ Death
☐ Loss of Eligibility ☐ COBRA Termination ☐ Divorce ☐ Other

OTHER:
☐ Name Change _____
☐ Address Change _____
☐ PCP Change Request _____
☐ Plan Change _____

EMPLOYEE INFORMATINON

SOCIAL SECURITY#: _____ **NAME OF EMPLOYER:** _____ **Occupation:** _____

Name: _____ **Date of Hire:** _____ **Requested Effective Date:** _____
Mailing Address: _____ ☐ New Enrollee Medicare? ☐ Yes ☐ No
E-mail Address: _____ ☐ Late Applicant Other Insurance? ☐ Yes ☐ No
Home Phone: ( ) _____ **Work Phone:** ( ) _____
Marital Status: _____ **Sex:** ☐ **Male** ☐ **Female** ☐ Reinstatement
If yes, name of carrier: _____
Insured's Name: _____ ID# _____

FAMILY INFORMATION

	LAST NAME	FIRST NAME	MI	DOB	SS#/CITIZENSHIP	COVERAGE			Add/Delete	PCP(HMO/Advantage Plan Only)
						Medical	Dental	Vision		
SELF					SSN: Citizenship:	☐	☐	☐	☐ Add ☐ Delete	
☐ HUSBAND ☐ WIFE					SSN: Citizenship:	☐	☐	☐	☐ Add ☐ Delete	
☐ SON ☐ DAUGHTER					SSN: Citizenship:	☐	☐	☐	☐ Add ☐ Delete	
☐ SON ☐ DAUGHTER					SSN: Citizenship:	☐	☐	☐	☐ Add ☐ Delete	
☐ SON ☐ DAUGHTER					SSN: Citizenship:	☐	☐	☐	☐ Add ☐ Delete	

WAIVER

I hereby waive my right to enroll my eligible dependents in NetCare during my Initial Enrollment Period. I understand that if I wish to enroll my dependents at a future date, enrollment will be subject to a qualifying event under HIPAA. Otherwise I must wait until my employer's next Annual Open Enrollment period.

☐ Coverage through Spouse's Employer: Employer Name: _____ Insurance Carrier: _____ Policy #: _____

☐ Coverage through Group, Prepaid, Government or State Medical Plan: Employer Name: _____ Insurance Carrier: _____

COVERAGE

Guam Plans: ☐ Standard Plan ☐ Advantage Plan ☐ POS ☐ HMO ☐ Smart Choice 1500 ☐ Smart Choice 2500 ☐ Prime Reward Plan ☐ Prime Plan ☐ Access Plan

CNMI Plans: ☐ CNMI Preferred Plan ☐ CNMI Standard Plan ☐ CNMI Prime Plan ☐ CNMI Limited Plan ☐ CNMI Limited 80/20 Plan

Palau Plans: ☐ Palau Preferred Plan ☐ Palau Prime Plan

INSURANCE INFORMATION

Please Provide Life Insurance Beneficiary information below (ONLY IF APPLICABLE TO YOUR PLAN)

_____ _____ _____
Beneficiary's Full Name Relationship to Employee Date of Birth/SS#

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 professional liability) are subject to binding arbitration. I have read the benefit brochure and any questions pertaining to the NetCare Health Plan have 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 my employer, and agree that I (we) will be bound by the terms and conditions therein contained. 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 Employer Signature (Application not valid without signature) Date

APEA0709

Send this Form