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: **Cobra election form must be submitted**
☐ 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: _____
E-mail Address: _____
Home Phone: ( ) _____ **Work Phone:** ( ) _____
Marital Status: _____ **Sex:** ☐ **Male** ☐ **Female**

☐ New Enrollee
☐ Late Applicant
☐ Special Enrollment
☐ Reinstatement

Medicare? ☐ Yes ☐ No
Other Insurance? ☐ Yes ☐ No
☐ PartA ☐ PartB ☐ PartD
If yes, name of carrier: _____
Insured's Name: _____ ID# _____

FAMILY INFORMATION

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

COVERAGE

GUAM PLANS: ☐ Platinum Preferred Plan ☐ Prime Plan ☐ Advantage Plan ☐ POS ☐ HMO ☐ Smart Choice 1500 ☐ Smart Choice 2500 ☐ Other _____

CNMI PLANS: ☐ CNMI Preferred Plan ☐ CNMI Standard Plan ☐ CNMI Prime Plan ☐ CNMI Limited Plan ☐ CNMI Limited 80/20 Plan ☐ Other _____

PALAU PLANS: ☐ Palau Preferred Plan ☐ Palau Prime Plan ☐ Other _____

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 _____

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