

Important Note to Eligible Live and Work Member

For the continuation of benefits and coverage under TakeCare Insurance Company, Inc. ("TakeCare"), this information form needs to be completed and submitted to TakeCare every benefit year within thirty (30) days after Open Enrollment or qualifying events. Please note that this form will be reviewed and validated by the TakeCare Underwriting Team.

Member Complete Information

TakeCare Group ID: ▼		TakeCare Member ID: ▼			
_____		_____			
Last Name: ▼		First Name: ▼		Social Security Number: ▼	
_____		_____		_____	
DOB: ▼	Name of Employer: ▼	Employer Group Effective Date: ▼	Title of Work: ▼	Telephone: ▼	Fax: ▼
_____	_____	_____	_____	_____	_____
Address of Employer: ▼			City: ▼	State: ▼	Zip Code: ▼
_____			_____	_____	_____
Complete Off Island Physical Address: ▼			City: ▼	State: ▼	Zip Code: ▼
_____			_____	_____	_____
Primary Care Provider: ▼			Primary Care Provider Contact Number: ▼		
_____			_____		
Primary Care Provider Address: ▼			City: ▼	State: ▼	Zip Code: ▼
_____			_____	_____	_____

Authorization

I authorize the information above to disclose to TakeCare, all information relative to my status as a Live and Work Member residing outside the service area as it pertains to past, current, or future TakeCare coverage and benefits.

Signature of Member	Date
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For TakeCare Management Use Only

Health Plan Administrator Signature	Date
Corporate Administrator Signature	Date
President/CEO Signature	Date

For TakeCare Underwriting Use Only

Reviewed/Validated by: ▼	Date: ▼
_____	_____

Notes:

Please return completed form to TakeCare Customer Service Department | Fax: 647-3542 | Email: customerservice@takecareasia.com