TakeCare℠

P.O. Box 6578 Tamuning, Guam 96931

COMMERCIAL CHANGE REQUEST FORM (CRF)

1 Subscriber's Name ▼ LAST NAME FIRST NAME M.I. **2** Social Security No. ▼

3 Employer Group Name ▼ **4** Home Telephone No. ▼ **5** Work Telephone No. ▼ EXT.

6 Subscriber's Mailing Address ▼ VILLAGE STATE ZIP CODE

FOR TAKECARE ONLY

SUBCRIBER ID NO. ▼

GROUP ID NO. ▼

SUBGROUP ID NO. ▼

MEDICAL PLAN ID ▼

DENTAL PLAN ID ▼

7 CHANGE OF PERSONAL INFORMATION ▼

☐ **Change my address/phone as indicated above**

☐ **Change my name* as shown above. My former name was**_____

* PLEASE ATTACH OFFICIAL DOCUMENTATION (i.e. Marriage Certificate, Court Order).

A DEPENDENT CHANGES ▼

Official supporting documentation will be required to enroll Eligible Dependents, including a spouse and children for the purpose of verifying eligibility. Please note that certain dependent relationships may not be recognized by your Group or the Health Plan. **PLEASE PRINT CLEARLY**.

***Note: PLEASE SPECIFY RELATIONSHIP TO YOU BELOW.** (For example: husband, wife, son, daughter, grandson, granddaughter, stepson/daughter, etc.)

NAME: Last	First	M.I.	IS DEPENDENT RESIDING OFF ISLAND? Yes/No	RELATION TO YOU	DOB	SSN	ADD MED	ADD DEN	PRIMARY CARE MEDICAL PHYSICIAN	DELETE MED	DELETE DEN

***COMMERCIAL MEDICAL/DENTAL LOCK-IN PROVISION:** Medical/Dental Coverage cancellation will only be allowed during open enrollment

B CLASS CHANGES ▼ (CLASS CHANGES MUST BE DIRECTLY REPORTED TO YOUR PERSONNEL DEPARTMENT.)

☐ Medical Change from: _____ to _____ Effective: _____

☐ Dental Change from: _____ to _____ Effective: _____

C MISCELLANEOUS CHANGES ▼ (PLEASE ATTACH OFFICIAL DOCUMENTATION, i.e. MARRIAGE/BIRTH CERTIFICATE, COURT ORDER TO SUPPORT NAME CHANGE.)

☐ Dependent Name Change from: _____ to _____

☐ Department Transfer from: _____ to _____ Effective: _____

☐ Other (Specify):_____ from _____ to _____ Effective: _____

D CANCELLATION OF COVERAGE (For Subscribers Only) : ▼

☐ Medical Coverage Effective: _____ ☐ Dental Coverage Effective: _____

*Subscriber's medical/dental coverage cancellation will only be allowed during open enrollment or when you resign/terminate your employment.

REASON FOR CANCELLATION

☐ Termination / Resignation from employment ☐ Enrolling under spouse's plan ☐ Rate too high

☐ Poor Provider Service ☐ Poor Customer Service ☐ Other (Specify)_____

I hereby acknowledge and understand that, per HIPAA provisions, my employer will notify the health plan of my termination from the Group Health Insurance Program. The health plan will provide a "Certificate of Coverage" that will assist me in obtaining future health insurance coverage upon request. I also acknowledge that, by affixing my signature, below I am indicating that I have read the subscriber agreement and temporary ID form instructions section on the back of this change request form.

E Employee Signature _____ Date_____

F GROUP VALIDATION AND EFFECTIVE DATE REQUIRED:

Authorized Employer Group Representative Signature_____ Date_____

▶ Effective: _____

For TakeCare Use Only

SCREEN ▶ ENTER ▶ CARDS ▶ VERIFY ▶

DISTRIBUTION: **White Original-**TakeCare **Yellow-**Personnel/HR **Pink-**Payroll **Blue-**Subscriber TCFORM CRF_090116

PLEASE READ CAREFULLY AND ACKNOWLEDGE BELOW

IF ADDING A DEPENDENT, THIS IS YOUR DEPENDENT'S TEMPORARY ID FORM

This form will serve as a temporary identification. It is valid for thirty (30) days from the effective date of coverage. However, in order to be valid, the form must be signed by you and your Group HR/Personnel Representative, as well as, be approved and accepted by TakeCare. Please keep it with you and present it each time you require services. You will be personally responsible for the cost of services if you are not eligible or the services are not covered. If you do not receive your dependent's membership card within thirty (30) days after you become eligible, please call our **Customer Service** number at GUAM **(671) 647.3526;** CNMI **(670) 235.7687 ;** PALAU **(680) 488.4715**.

SUBSCRIBER AGREEMENT SECTION

"I hereby authorize my employer to deduct from my earnings any employee contribution required to cover my share of the premium for group benefits for which I am eligible. I agree that I shall abide by the provisions of coverage in the TakeCare Group Policy under which I am enrolled. I understand that it is my responsibility to report any changes in the eligibility of my dependents. I further understand that newly eligible dependents may only be added within thirtyone (31) days from becoming eligible or during the open enrollment period of my group. I have read and understand the eligibility requirements and attest that all my dependents and I meet these requirements. I agree to provide TakeCare all documents necessary to support eligibility. I understand that TakeCare has the right to request required documents at anytime after enrollment. I understand that failure to submit required documents would result in a loss of coverage or services at the discretion of TakeCare. Should this occur, I understand and agree that I will be responsible for the cost of all healthcare services provided to me and/or my dependents. I understand that providing coverage and services do not constitute acceptance of my eligibility by TakeCare until I provide all documents requested by TakeCare to provide my dependents' and my eligibility for coverage. I also give my consent to TakeCare or its designee to access and use my medical records or the medical records of my dependents to assure correct and timely medical diagnosis and for purposes, as required by law, of Utilization Review, Quality Assurance, surveys and processing of claims. I understand that any claims asserted by my dependents or me against TakeCare, its employees or agents, whether based in contract, tort or otherwise for professional liability, are subject to binding arbitration. I have received a copy of the TakeCare member handbook that contains the benefits, limitations and exclusions applicable to my healthcare plan. I understand that any material omission or intentional misrepresentation in answering the questions on this form may result in the denial of benefits and termination of my dependent(s) or my coverage. I agree and understand that TakeCare will charge an additional service, collection, or attorneys fee for the collection of any amounts owed to TakeCare or the processing of a returned check for services rendered or products purchased on behalf of members covered by this plan. I also give my consent to TakeCare or its designee to request and obtain Medicare eligibility information regarding all members covered by my plan."

Employee's Initials _____ Date_____