TakeCare℠

P.O. Box 6578 Tamuning, Guam 96931

COMMERCIAL GROUP
Enrollment Form

1 Group/Employer Name ▼

2 Date Employed ▼

3 Medical Coverage ▶

☐ **Guam**
- ☐ Gold Premier
- ☐ Platinum Premier 0
- ☐ Platinum Premier 5
- ☐ Silver Premier 1500
- ☐ Silver Premier 250
- ☐ Bronze Premier
- ☐ Others: Please specify _____

☐ **CNMI**
- ☐ Platinum Premier CW
- ☐ Platinum Premier 5
- ☐ Platinum Premier 10
- ☐ Platinum Premier 20%
- ☐ Others: Please specify _____

☐ **Palau**
- ☐ Premier _____
- ☐ Basic

4 Medical Class ▶
- ☐ Employee Only
- ☐ Employee and Spouse
- ☐ Employee & 1 Child
- ☐ Employee & Children
- ☐ Employee with Spouse & Children

5 Dental Coverage ▶ ☐ **Dental**
- ☐ Dental 8550 $1,000
- ☐ Dental 8850 $1,500
- ☐ Dental 8880 $3,000
- ☐ Others: Please specify _____

6 Dental Class ▶
- ☐ Employee Only
- ☐ Employee and Spouse
- ☐ Employee & 1 Child
- ☐ Employee & Children
- ☐ Employee with Spouse & Children

7 Employee Name ▼ LAST NAME FIRST NAME M.I.

8 Date of Birth ▼

9 Gender ▼ ☐ M ☐ F

10 Social Security No. ▼

11 Employee Title ▼

Employee ID No. ▼

12 Mailing Address ▼ VILLAGE STATE ZIP CODE

13 Home Telephone No. ▼

14 Work Telephone No. ▼

15 Mobile Phone No. ▼

16 Email Address ▼

17 Please list enrollees below starting with yourself, your spouse (if any), and then any children to be covered by the Health Plan. Official supporting documentation will be required to enroll Eligible Dependents, including your spouse and children, for the purpose of verifying eligibility. Specify the relationship of each dependent to you (for example: husband, wife, son, daughter, etc.). Please note that certain dependent relationships may not be recognized by your Group or the Health Plan. **PLEASE PRINT CLEARLY**.

NAME: Last First M.I.	RELATION TO YOU* (spouse, son, daughter, etc.)	IS DEPENDENT RESIDING OFF ISLAND? Yes/No	SSN	DOB	ENROLL IN MED or DEN?	FOR TAKECARE USE
	SELF				☐MED ☐DEN	
					☐MED ☐DEN	
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Is anyone, listed above, have a different address other than the one listed by the Subscriber? ☐ YES ☐ NO If YES who and what is their address? Please list below.

To help us coordinate your care, please answer the following questions. Any omission of information or intentional misrepresentation in answering the following questions concerning you and your dependents may result in denial of benefits and termination of your coverage.

18 Is anyone, listed above, in the hospital? ☐ YES ☐ NO If YES, who? _____

19 Is anyone, listed above, receiving ongoing medical or dental care for any illness/condition? ☐ YES ☐ NO
If YES, whom, for what illness and under which provider? _____

20 Does anyone, listed above, have other health insurance in addition to TakeCare? ☐ YES ☐ NO If YES, please fill out below.

Member Name(s): _____ Other Health insurance: _____

Name of Policy Holder: _____ Policy No.: _____ Effective Date: _____

21 Does anyone, listed above, have MEDICARE coverage? ☐ YES ☐ NO If YES, please fill in section below.

(1) Member Name: _____ MEDICARE No.: _____
☐ PART A - Effective Date: _____ ☐ PART B - Effective Date: _____ ☐ PART D - Effective Date: _____

(2) Member Name: _____ MEDICARE No.: _____
☐ PART A - Effective Date: _____ ☐ PART B - Effective Date: _____ ☐ PART D - Effective Date: _____

You accept the health insurance coverage provided through this employer by signing on the space provided below. By signing below, you agree to the terms of the subscriber agreement section, temporary ID form and deductible plan instructions on the back of this enrollment form.

22 Employee Signature _____ Date _____

***Commercial Medical/Dental Lock-In Provision:** Medical/Dental Coverage voluntary cancellation will only be allowed during open enrollment

23 **GROUP VALIDATION AND EFFECTIVE DATE REQUIRED:**
Employer Group Representative Signature _____ Date _____

▶ Medical Effective Date ▶ Dental Effective Date ▶

For TakeCare Use Only

GROUP ID ▶ SG ID ▶ CLASS ▶ SCREEN ▶ SUB ID ▶

MED ID ▶ DEN ID ▶ ENTER ▶ CARDS ▶ VERIFY ▶

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

TCFORM_EF_08112017

PLEASE READ CAREFULLY AND ACKNOWLEDGE BELOW

THIS IS YOUR 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.**

FOR MEMBERS ENROLLED IN PLANS WITH DEDUCTIBLES

1. Members can present their TakeCare ID card during visits to their doctor or lab to receive TakeCare contracted rates on health services received.
2. Only claims from visits to doctors, labs or pharmacies within the TakeCare network will be accumulated in full towards deductibles. Any claims for visits to non-participating doctors, labs or pharmacies will be accumulated at 70% of eligible charges.
3. Full payment of health services is the responsibility of the member at the time of the doctor, lab or pharmacy visit until the deductibles are met.
4. A TakeCare Deductible Claim Form should be filled out immediately and kept safe to ensure accurate and complete information on all doctor, labor pharmacy visits.
5. When the total payments of an individual member's medical visits equals or surpasses their plan deductible amount, the member should submit Deductible Claim Form(s) and accompanying receipts and invoices to the TakeCare Customer Service Department.
6. After review and confirmation that deductibles have been met, medical plan benefits as specified in the schedule of benefits will be in effect.

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 Insurance 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 thirty-one (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 with 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 after determination by 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 does not constitute acceptance of eligibility by TakeCare. Eligibility will be determined after I provide all documents requested by TakeCare to support 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 Take-Care member handbook and schedule of benefits that contain 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 attorney's 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_____