TakeCare℠
A TanHoldings Company
P.O. Box 6578 Tamuning, Guam 96931

GOVERNMENT OF GUAM
Medical Enrollment Form/Change Request Form

1 Type of Request ▼
- ❍ **Initial Enrollment**
- ❍ **Terminate Coverage**
- ❍ **Change of Status:** Please indicate the type of change and make the necessary selections or updates in the required sections.
- ❑ **Update Personal Information, Change to:** _____

❑ Add Dependent ❑ Delete Dependent
❑ Plan Change ❑ Class Change
❑ Update information ❑ Name Change

2 Agency/Department ▼

3 Date Employed ▼ / /

4 Employee Status ▼
- ❍ **Employee**
- ❍ **Retiree**
- ❍ **Survivor**

If retiree or survivor, are you under:
❍ **DB** or ❍ **DC**

5 ❑ **Medical Plan**

▼ ❍ **PPO1500** ❍ **HSA2000**
- ❍ **Class I:** Subscriber Only
- ❍ **Class II:** Subscriber + Spouse/Domestic Partner
- ❍ **Class III:** Subscriber + Child/ren
- ❍ **Class IV:** Subscriber + Spouse/Domestic Partner & Child/ren

6 Retiree Supplemental Plan ▼ **Medicare A & B Primary, must enroll election for 1500/2000 plan for non-medicare members**

❑ Medical Plan
- ❍ I - Subscriber Only
- ❍ II - Subscriber + Spouse (Domestic Partner) Only / RSP Plan both enrolled in Medicare A & B
- ❍ IIb - Subscriber + Spouse/Domestic Partner (Retiree enrolled under Medicare A&B)
- ❍ III - Subscriber + Child(ren) Only-RSP Medicare enrolled with No Spouse (Domestic Partner)
- ❍ IV - Subscriber + Family (Spouse/Domestic Partner & Child/ren)
- ❍ IVb - Subscriber + Spouse/Domestic Partner + Child(ren) (Retiree enrolled under Medicare A&B)

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

8 Date of Birth ▼ / /

9 Gender ▼ ❍ **Male** ❍ **Female** ❍ **X** (Unspecified or another gender identity)

10 Social Security No. ▼

11 Employee Title ▼

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/domestic partner (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/domestic partner and children, for the purpose of verifying eligibility. Specifiy the relationship of each dependent to you (for example: husband, wife, domestic partner, 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	Add	Delete	GENDER (Male, Female or X=Unspecified or another gender identity.)	SSN	DOB
			SELF						/ /
									/ /
									/ /
									/ /
									/ /
									/ /

To help us coordinate your care, please answer the following questions. Any omission of information or intentional misrepresentation in answering the following questions of you and your dependents may result in denial of benefits and the 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 care for a chronic illness/condition? ❍ YES ❍ NO
If YES, whom and for what illness? _____

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:** _____

***Government Medical/Prescription Lock-In Provision: Medical/Prescription cancellation will only be allowed during open enrollment.**

22 **MISCELLANEOUS CHANGES** ▼ (CLASS CHANGES MUST BE DIRECTLY REPORTED TO YOUR PERSONNEL DEPARTMENT)

❑ **Medical** Change from: _____ to _____ Effective: _____ ❑ **Prescription** Change from: _____ to _____ Effective: _____

❍ **Add** ❍ **Delete** dependent(s) (in item #17) from: _____ to _____ Effective: _____
(PLEASE ATTACH OFFICIAL DOCUMENTATION, i.e. MARRIAGE/BIRTH CERTIFICATE, COURT ORDER TO SUPPORT NAME CHANGE)

❍ Subscriber ❍ Dependent Name Change from: _____ to _____

❍ Agency/Department from: _____ to _____ Effective: _____

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

23 **CANCELLATION OF COVERAGE (For Subscribers Only):** ▼

❑ Medical Coverage Effective: _____ ❑ Prescription Coverage Effective: _____
*Subscriber's medical/prescription/ cancellation will only be allowed during open enrollment or when you resign/terminate your employment.

REASON FOR CANCELLATION
❍ Termination / Resignation from employment

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

24 Employee Signature _____ Date _____

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

❍ Applicable supporting documents attached ▶ **Medical** Effective Date _/_ /_ ▶ Pay Period Ending Date _/_ /_

For TakeCare Use Only

GROUP ID ▸ SG ID ▸ CLASS ▸ MED ID ▸ DEN ID ▸

SCREEN ▸ ENTER ▸ VERIFY ▸ SUB ID ▸

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

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 one (31) 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 one (31) days after you become eligible, please call our **Customer Service** number at **(671) 647.3526.**

FOR MEMBERS ENROLLED IN PLANS WITH DEDUCTIBLES

1. Members can present this temporary 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 medical 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, lab or pharmacy visits.

5. When the total payments of an individual member's medical visits equals or surpasses their plan deductible amount, they 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, a medical plan benefits as specified in 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. If I am on Leave Without Pay (LWOP), then I hereby agree that I am responsible for my premium payments 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 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 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 the dispute resolution procedures set forth in the Group Health Insurance Certificate. Adverse benefit determinations, including rescissions of coverage, are subject to the PPACA Claims Procedures. I have received a copy of the Group Health Insurance Certificate 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_____

Medical Enrollment / Change of Status Form
Government of Guam

Calvo's SelectCare Health Plans

Employment Status: ☐ Active Employee ☐ Retiree ☐ Survivor of Retiree ☐ DC Retirement Plan ☐ DB Retirement Plan

First Name	M.I.	Last Name

GovGuam Agency/Department	Date of Employment	Social Security No.

Mailing Address	City	State	Zip

Home Phone	Work Phone & Ext.	Cell Phone / Other Phone	Date of Birth	Sex	Marital Status

E-mail Address

☐ New Enrollee - Check ✓ this item if you are a NEW ENROLLEE.

☐ Terminate Coverage - You may only terminate your coverage during the Open Enrollment Period or upon Termination of Employment.

☐ Change Of Status - Make appropriate checks ✓ to the items below.

☐ Add Dependent(s) ☐ Delete Dependent(s) ☐ Update Information ☐ Deduction Class Change ☐ Plan Change

Health Plan Choice

☐ **HSA 2000** (Single Ded. is $2,000 / Family Ded. is $4,000.)

☐ **PPO 1500** (Single Ded. is $1,500 / Family Ded. is $3,000.)

☐ **Retiree Supplemental Plan (RSP)** (Must be enrolled in Medicare A and B and you must fill out "Other Insurance" below)

Deduction Class for HSA2000 AND PPO1500 Plans

- ☐ **Class I** Subscriber Only
- ☐ **Class II** Subscriber + Spouse/Domestic Partner
- ☐ **Class III** Subscriber + Child(ren)
- ☐ **Class IV** Subscriber + Spouse/Dom. Partner & Child(ren)

Deduction Class for RSP

Please elect a plan for non-medicare dependents if applicable: ☐ **HSA2000** ☐ **PPO1500**

- ☐ **Class I** RSP Subscriber Only
- ☐ **Class II** RSP Subscriber + RSP Spouse/Domestic Partner
- ☐ **Class IIb** RSP Subscriber + Non Medicare Spouse/Dom. Partner
- ☐ **Class III** RSP Subscriber + Non Medicare Child(ren)
- ☐ **Class IVa** RSP Subscriber + RSP Spouse/Dom. Partner + Non Medicare Child(ren)
- ☐ **Class IVb** RSP Subscriber + Non Medicare Spouse/Dom. Partner & Child(ren)

Dependent Information

Spouse/Domestic Partner & dependent children up to 26 years of age.
Only fill out Address/Email information below for Dependent(s) opting to receive correspondence separately.

Last Name	First Name & M.I.	Relation to Subscriber	Social Security Number	Sex	Date of Birth
Mailing Address			Email Address		
Last Name	First Name & M.I.	Relation to Subscriber	Social Security Number	Sex	Date of Birth
Mailing Address			Email Address		
Last Name	First Name & M.I.	Relation to Subscriber	Social Security Number	Sex	Date of Birth
Mailing Address			Email Address		
Last Name	First Name & M.I.	Relation to Subscriber	Social Security Number	Sex	Date of Birth
Mailing Address			Email Address		
Last Name	First Name & M.I.	Relation to Subscriber	Social Security Number	Sex	Date of Birth
Mailing Address			Email Address		
Last Name	First Name & M.I.	Relation to Subscriber	Social Security Number	Sex	Date of Birth
Mailing Address			Email Address		
Last Name	First Name & M.I.	Relation to Subscriber	Social Security Number	Sex	Date of Birth
Mailing Address			Email Address		

Other Insurance

Do you or will you or any of your covered dependents have other health coverage?
If "Yes", please indicate which other coverage will apply and the effective date of such coverage.

Person with Dual Health Insurance Coverage	Medicare Part A	Medicare Part B	Medicare Part D	Medi-caid	Other Insurance Carrier	Medical	Dental	Effective Date

I agree that I shall abide by the provisions of coverage in the policy under which I am enrolled. I have read and understand the eligibility requirements and attest that I and all dependents meet these requirements. 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 31 days from becoming eligible or during an Open Enrollment period for my group. I understand that Calvo's SelectCare has the right to request required documents at any time and failure to submit these documents may result in a loss of coverage or service at the discretion of Calvo's SelectCare . Should this occur, I understand and agree I may be responsible for the cost of all health care provided to me and my dependents. I understand that the providing of coverage and service does not constitute acceptance of eligibility by Calvo's SelectCare until eligibility for coverage has been proven.

I authorize any Medical/Healthcare Provider or Facility to give Calvo's SelectCare information concerning the medical history, prescription utilization history, services or treatment provided to anyone I have enrolled on this form, including any Mental Health, Substance Abuse and HIV/AIDS information. I further authorize Calvo's SelectCare to use such information and to disclose such information to affiliates, other Providers, payors, other insurers, third party administrators, vendors, consultants and government authorities with jurisdiction when as deemed necessary by Calvo's SelectCare for my care or treatment, payment of services, the operation of my health plan, or to conduct related activities. I have discussed the terms of this authorization with my spouse and competent adult dependents and I have obtained their consent to those terms. This authorization will remain valid for the term of the coverage and so long thereafter to finalize the administration of any remaining open claims. I understand that I am entitled to receive a copy of this authorization and that a photocopy is as valid as the original. I have read the benefit brochure and my questions pertaining to the Calvo's SelectCare Plan have been answered satisfactorily and will be further explained upon my request. I hereby authorize my employer to deduct any required cost for this program. I further agree that I will pay the premium, including my employer's portion, for any periods where I am on Leave Without Pay (LWOP) directly to Calvo's SelectCare.

For Official Use Only:

Date: ______ Pay Period Ending: ______

Supporting Docs: ______ Signature: ______

Signature of Employee **Date Signed**

Distribution: White=SelectCare Yellow=Personnel Pink=Payroll Gold=Member