Live And Work Enrollment Form

TakeCare℠

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 submitted to TakeCare 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

Last Name: | First Name: | TakeCare Member ID: | 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

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