Health & Welfare Plan

ENROLLMENT APPLICATION

All fields and questions must be answered. If not applicable, please write N/A. Any changes made to this form must be initialed.

PLEASE COMPLETE THE GENERAL INFORMATION BELOW

☐ FULL-TIME (30+ Hours/Week) - Are you buying up to the Silver 100 Plan? ☐ Yes ☐ No

☐ HALF-TIME (20-29 Hours/Week) ☐ PART-TIME (1-19 Hours/Week)

LAST NAME	FIRST NAME	M.I.
MAILING ADDRESS (Street, City, State, Zip Code)		

GENDER	MARITAL STATUS ☐ Single/Widowed ☐ Married ☐ Common Law/Domestic Partner ☐ Divorced	DATE OF BIRTH (MM/DD/YYYY)	EMAIL ADDRESS

SOCIAL SECURITY NO.	HOME PHONE	WORK PHONE (INCL. EXT.)	OTHER CONTACT NO.

EMPLOYER	JOB TITLE	DIVISION/DEPARTMENT	DATE OF EMPLOYMENT

SPOUSE'S NAME	SPOUSE'S EMPLOYER	SPOUSE'S CONTACT NO.

LIST ALL MEDICAL INSURANCE COVERAGE WITHIN THE LAST 12 MONTHS (Including Medicare/Medicaid/MIP)

Name of Insurance	Name of Insured	Group or Individual	EFFECTIVE DATE	TERMINATION DATE
		☐ ☐		
		☐ ☐		

LIST ALL FAMILY MEMBERS YOU WISH TO ENROLL Attach additional sheets if necessary.

RELATIONSHIP	LAST NAME	FIRST NAME	M.I.
1. SPOUSE	SOCIAL SECURITY NO. / BIRTHDATE (MM/DD/YY)	GENDER	EMAIL ADDRESS

RELATIONSHIP	LAST NAME	FIRST NAME	M.I.
2._____	SOCIAL SECURITY NO. / BIRTHDATE (MM/DD/YY)	GENDER	EMAIL ADDRESS (if 18 years old or older)

RELATIONSHIP	LAST NAME	FIRST NAME	M.I.
3._____	SOCIAL SECURITY NO. / BIRTHDATE (MM/DD/YY)	GENDER	EMAIL ADDRESS (if 18 years old or older)

RELATIONSHIP	LAST NAME	FIRST NAME	M.I.
4._____	SOCIAL SECURITY NO. / BIRTHDATE (MM/DD/YY)	GENDER	EMAIL ADDRESS (if 18 years old or older)

_____ NAME OF BENEFICIARY (FIRST, MIDDLE INITAL, LAST) _____ RELATIONSHIP TO EMPLOYEE

_____ NAME OF BENEFICIARY (FIRST, MIDDLE INITAL, LAST) _____ RELATIONSHIP TO EMPLOYEE

I hereby authorize my employer to deduct from my paycheck any required contribution for plan benefits for which I am eligible and to release any information regarding payment and leave status in order to facilitate medical services I might require. I agree to abide by the provisions of the Agreement of the plan 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 30 days from becoming eligible or during a special enrollment or during the open enrollment period of my group. I (and my dependents) hereby authorize any medical health care provider or facility that has any records or knowledge of me (us) or my (our) health to give StayWell any such information. A photographic copy of this authorization shall be valid as the original. I have read a copy of the brochure which contains the benefits, limitations and exclusions applicable to my health care plan. I understand that the coverage for which I am eligible will be further explained, UPON REQUEST, by a StayWell representative or my personnel officer. I understand that StayWell has the right to request for additional documents as needed to determine eligibility. I understand and agree that I may be responsible for the cost of all health care provided to me and my dependents should a loss of coverage occur.

By signing below, my dependents and I agree to receive marketing and promotional material from StayWell Insurance to the contact information provided. I understand that I/we have the right to opt-out from receiving such materials at any time, and may do so by checking the box below or by emailing marketing@staywellguam.com.

☐ I/We prefer not to receive marketing and promotional material from StayWell Insurance

_____ APPLICANT'S SIGNATURE _____ DATE SIGNED

FOR INTERNAL USE ONLY			
ENROLLMENT	**CUSTOMER CARE**	**MARKETING**	**NOTES**
Group No.:	Received by:	Representative:	
Entered By:	Received date:		
Entered Date:	**UNDERWRITING**	Manager:	
Effective Date:	Reviewed by:	Reviewed by:	
Member No.:	Received by:	Effective Date:	