Application for Enrollment

COMMERCIAL GUAM ☐ COMMERCIAL CNMI ☐

StayWell INSURANCE

ALL FIELDS AND QUESTIONS MUST BE ANSWERED. IF NOT APPLICABLE, PLEASE WRITE N/A. ANY CHANGES MADE TO THIS FORM MUST BE INITIALED.

CHOOSE ONE MEDICAL PLAN

☐ GOLD ☐ SILVER ASIA PACIFIC ☐ CW 100 ☐ OTHER

☐ GOLD12 ☐ 7030 ☐ CW 8020 _____

☐ SILVER ☐ BRONZE ☐ RCW8020

CHOOSE ONE OPTION

☐ MEDICAL ONLY

☐ MEDICAL & DENTAL

CHOOSE ONE CLASS

☐ CLASS I — Employee Only

☐ CLASS II — Employee + 1

☐ CLASS III — Employee + 2 or More

LAST NAME	FIRST NAME	M.I.
MAILING ADDRESS (Street, City, State, Zip Code)		
GENDER	MARITAL STATUS ☐ Single/Widowed ☐ Married ☐ Common Law/Domestic Partner ☐ Divorced	BIRTHDATE (MM/DD/YY)
EMAIL ADDRESS	SOCIAL SECURITY NO.	
HOME PHONE	WORK PHONE (INCL. EXT.)	OTHER CONTACT NO.
EMPLOYER	JOB TITLE	
DATE OF EMPLOYMENT (MM/DD/YY)	PROBATION PERIOD ☐ NONE ☐ 30 DAYS ☐ 60 DAYS ☐ 90 DAYS ☐ OTHER: _____	CONTRACT WORKER ☐ YES ☐ NO
SPOUSE'S NAME	SPOUSE'S EMPLOYER	SPOUSE'S CONTACT NO.

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

Attach additional sheets if necessary

Name of Insurance	Name of Insured/Dependent	Group	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)

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 my eligibility and 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 agree to provide StayWell all documents necessary to support eligibility. I understand that StayWell has the right to request for additional documents as needed at any time after enrollment. I understand that failure to submit required documents would result in a loss of coverage or services at the discretion of StayWell. I have read and understand the eligibility requirements and attest that I and all my dependents meet these requirements. I further understand I (and my dependents) will lose eligibility upon resignation or termination, unless I am eligible for COBRA and elect COBRA. I understand and agree that I will be responsible for the cost of all health care provided to me and my dependents should a loss of coverage occur. I understand that providing coverage and services do not constitute acceptance of my eligibility by StayWell until I provide all documents requested by StayWell to provide my dependents' eligibility and my eligibility for coverage. 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 StayWell will charge an additional service, collection or attorney fee for the collection of any amounts owed to StayWell for services rendered or products purchased on behalf of members covered by the Plan. 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, including any Mental Health, Substance Abuse and HIV/AIDS information. I have discussed the terms of this authorization with all competent adults named in this form and I have obtained their consent to those terms. 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.

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

_____ EMPLOYEE'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:	