AUTHORIZATION

I authorize any physician, surgeon, practitioner, hospital, medical care institution, insurance company or other organization, institution, person or employer that has any records, knowledge of care, treatment or advice of me/or my dependents, to give such information to StayWell or its representatives, including any Mental Health, Substance Abuse and HIV/AIDS information. This authorization or a photographic copy remains in effect as long as necessary to evaluate my application and process claims for me and/or my dependents. A photographic copy of this authorization shall be valid as the original. 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.

AGREEMENT

I understand that StayWell has the right to reject my application as allowed by local or federal law and if so, I will be notified in writing and StayWell is not obligated to disclose the reason for refusal. If StayWell rejects my application, under no circumstance will any benefits be payable for any person listed on this application. By signing this Application for Enrollment and returning it to StayWell, I am applying for health benefits for myself and/or my dependents who are listed in this Application for Enrollment.

NOTICE

Enrollment in the Plan shall be limited to only those who are domiciled in the Service Area except for eligible dependent children residing outside the Service Area. I understand that StayWell may need to clarify with me my/my dependents' answers and my/my dependents' presence in Guam while my application is being processed. If not in Guam while the application is being processed, I understand that this may result in a delay in StayWell's review.

Approval of this Application for Enrollment is subject to special exclusions, as StayWell may, in its exclusive judgment, deem appropriate as conditions for enrollment by reason of the applicant's physical condition or prior, current, or potential health condition, as allowed by local or federal law. **StayWell reserves the right to refuse membership to any such applicant by reason of any prior, current, or potential health condition, and is not obligated to disclose the reason for refusal.**

I hereby certify that the foregoing answers are true and complete and to the best of my knowledge. If any condition, disease or change in health status occurs after I complete this Application for Enrollment, but before the effective date, I must immediately update this Application for Enrollment by sending a written explanation to StayWell Insurance, **520 Route 8 Maite, GU 96910, Attention: Underwriting Department**. If I fail to provide this updated information, or if I provide any incorrect or incomplete answer on this Application for Enrollment or in future correspondence concerning this Application for Enrollment, my coverage and/or my dependents' coverage may be terminated at any time.

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

I HAVE READ THE ABOVE CONDITIONS AND I CERTIFY THAT THE INFORMATION FURNISHED IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE. I AM RESPONSIBLE FOR THE ACCURACY AND COMPLETENESS OF THIS APPLICATION.

If applicant is under the age of 18, parent or guardian must sign.

PRINT NAME OF APPLICANT	SIGNATURE OF APPLICANT	BIRTHDATE (MM/DD/YY)	Last 4 Digits of SSN	DATE
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