☐ NEW ENROLLMENT

☐ CHANGE OF STATUS TO ADD DEPENDENT

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	HEIGHT	WEIGHT	MARITAL STATUS	BIRTHDATE (MM/DD/YY)
			☐ Single/Widowed ☐ Married ☐ Common Law/Domestic Partner ☐ Divorced	

EMAIL ADDRESS	AGE	SOCIAL SECURITY NO.

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

EMPLOYER	JOB TITLE

DATE OF EMPLOYMENT (MM/DD/YY)	PROBATION PERIOD	CONTRACT WORKER
	☐ NONE ☐ 30 DAYS ☐ 60 DAYS ☐ 90 DAYS ☐ OTHER _____	☐ YES ☐ NO

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

WERE YOU OR ANY OF YOUR DEPENDENTS PREVIOUSLY INSURED BY STAYWELL? **Yes** ☐ **No** ☐

NAME(S)

PLEASE INDICATE DATES PREVIOUSLY INSURED BY STAYWELL:

_____ EFFECTIVE DATE:_____ TERMINATION DATE:_____

ARE YOU CURRENTLY COVERED UNDER ANY HEALTH INSURANCE PLAN? **Yes** ☐ **No** ☐

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

NAME OF INSURANCE	NAME OF INSURED/DEPENDENT	GROUP/EMPLOYER NAME	EFFECTIVE DATE:	TERMINATION DATE:
NAME OF INSURANCE	NAME OF INSURED/DEPENDENT	GROUP/EMPLOYER NAME	EFFECTIVE DATE:	TERMINATION DATE:

Employee Name & Initial: _____ Date: _____

Dependents Information

StayWell INSURANCE

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)	AGE	GENDER
	HEIGHT	WEIGHT	EMAIL ADDRESS	

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

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

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

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

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

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

Employee Name & Initial:_____ Date: _____

Application for Enrollment

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.

HEALTH QUESTIONNAIRE: All questions must be marked [×] **Yes** or **No**. If answered "Yes", circle the appropriate condition(s) and give details in the space provided on page 4.

		Yes	No
1.	**Have you or any applying family member ever received any professional medical advice or treatment or had any symptoms pertaining to any of the following conditions?**		
a.	Dizziness, seizure, epilepsy, migraine, paralysis, stroke, muscular dystrophy, multiple sclerosis, cerebral palsy or other brain or nervous system disease or disorder?		
b.	Hypertension or high blood pressure, palpitation, chest pain, high cholesterol level, hyperlipidemia, ischemic heart disease, coronary artery disease (CAD), heart attack, heart murmur, heart valve problem, rheumatic fever or other heart or cardiovascular disease or disorder?		
c.	Anemia, varicose veins, peripheral vascular disease, phlebitis, bleeding problem or other circulatory system disease or disorder?		
d.	Allergies, asthma, reactive airway disease, sinusitis, emphysema, tuberculosis, chronic obstructive pulmonary disease (COPD) or other respiratory disease or disorder?		
e.	Mouth, tongue, esophageal or stomach problem, ulcer, intestinal bleeding, gallbladder stone, jaundice, cirrhosis, hepatitis, pancreatitis, polyp, hernia, hemorrhoids or other digestive disease or disorder?		
f.	Kidney stone, urethral stricture, bladder problem, infection or other urinary tract disease or disorder?		
g.	Male Reproductive System: such as prostate problem, infertility, impotence, gynecomastia, syphilis, gonorrhea or other venereal disease or others?		
h.	Female Reproductive System: such as breast mass, implants, endometriosis, fibroids, myoma, vaginal bleeding, vaginitis, abnormal Pap test, infertility, genital warts, Chlamydia infection or other menstrual or gynecological disease or disorder?		
i.	Arthritis, sciatica, herniated or bulging disc, scoliosis, carpal tunnel syndrome, fractures or other muscle or bone disease or disorder including back or joints?		
j.	Diabetes, goiter, gout, adrenal disorder, growth hormone deficiencies, lupus, acquired immune deficiency syndrome (AIDS), or other metabolic, endocrine, nutritional and immune system disease or disorder?		
k.	Skin cancer, dermatitis, eczema, mole, acne, psoriasis, warts, skin tags, birthmarks, burns or other skin disease or disorder?		
l.	Cataract, glaucoma, retinal detachment, pterygium, crossed eyes, polyp, deviated nasal septum, sleep apnea, tonsils and adenoids problems or other eyes, ears, nose or throat disease or disorder?		
m.	Cancer, cyst, or tumor, Leukemia, Hodgkin's disease, Lymphoma or other blood or lymph disease or disorder?		
n.	Down syndrome, cleft lip or palate, clubfoot, developmental delay, mental retardation or other birth defect or congenital disease or disorder?		
o.	Alcoholism, Drug dependency or Substance abuse?		

If you answered "Yes" to any of the questions above, please give details on page 4.

2.	**Have you or any applying family member received any counseling, medical advice, care or treatment for symptoms of depression, anxiety, panic attack, nervousness, schizophrenia, attention deficit disorder, mental or emotional disorder, behavioral problem, autism or for any other reasons not mentioned previously?**		
3.	**Have you or any applying family member ever had surgery of any kind including reconstructive or cosmetic, prosthesis, stents, implants, retained hardware, organ transplant or other surgery for any other reasons?**		
4.	**Have you or any applying family member ever had abnormal laboratory results, X-rays, EKG, Echocardiogram, ultrasound, nerve condition test, MRI, CT scan or other procedure?**		

Employee Name & Initial: _____ Date: _____

5.	Have you or any applying family member advised to undergo further testing, treatment, surgery or organ transplant which has not yet been performed by a physician, dentist or other health providers?		
6.	Have you or any applying family member ever had any application for health or life insurance declined, postponed or restricted in any way?		
7.	Are you or any applying family member disabled, hospitalized or receiving medical care in the home at this time?		
8.	Have you or any applying family member ever had a pregnancy resulting in cesarean section or is one anticipated?		
9.	Within the past five (5) years, has anyone named in this application had any examination, hospitalization, treatment, medical advice or surgery not mentioned above?		

Provide details below if you answered "Yes" to any parts of questions 1 to 9.

Question No.	Name of Family Member	Name of Condition & Type of Treatment Received	Dates of Treatment From & To (MM/DD/YY)	On-Going (Yes/No)	Name of Physician (Clinic/Hospital)

If more space is required, provide additional details on a separate sheet of paper. Please sign and date the additional sheet(s) used.

LIST ANY UPCOMING MEDICAL APPOINTMENT(S):

Name of Family Member	Name of Physician (Clinic/Hospital)

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

10. **FOR FEMALE APPLICANTS ONLY** ☐ Subscriber ☐ Spouse

a. When was your last menstrual period?_____

List dates of last menstrual period for all other dependents:

Name: _____ Date: _____

Name: _____ Date: _____

Name: _____ Date: _____

b. If pregnant, when is the expected date of delivery?_____

Employee Name & Initial: _____ Date: _____

11. Are you or any applying family member currently taking any medication or have you taken any medication in the past twelve (12) months? If Yes, please list below.

Name of Family Member	Name and dosage of medication and condition for which medication was prescribed	Dates of medication intake (MM/DD/YY)	On-Going (Yes/No)	Name of Physician (Clinic/Hospital)

12. Have you or any applying family member ever smoked cigarettes? ☐ Yes ☐ No

Family Member	Packs/Day	Years Smoked	Quit? If "Yes", what year?

13. Do you or any applying family member drink alcoholic beverages? ☐ Yes ☐ No

Family Member	Drinks/Week	Type

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.

EMPLOYEE'S NAME & SIGNATURE _____ DATE SIGNED _____

All applicants/guardian must sign on Page 6.

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:	

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