☐ NEW ENROLLMENT

☐ CHANGE OF STATUS TO ADD DEPENDENT

# Application for Enrollment

## CNMI GOVERNMENT EMPLOYEE PERSONAL PLAN

StayWell INSURANCE

**CHOOSE ONE OPTION:**

☐ MEDICAL ONLY

☐ MEDICAL & DENTAL

**CHOOSE ONE CLASS:**

☐ CLASS I — Single

☐ CLASS II — Couple

☐ CLASS III — Family

| LAST NAME | FIRST NAME | M.I. | DATE OF BIRTH | SEX |
|---|---|---|---|---|
| | | | | |

| MAILING ADDRESS | HOME PHONE |
|---|---|
| | |

| PLACE OF EMPLOYMENT/ASSOCIATION | OCCUPATION | WORK PHONE |
|---|---|---|
| | | |

| MARRIED? ☐ Yes ☐ No | SPOUSE NAME (if spouse will be included, please list below) | SPOUSE'S PLACE OF EMPLOYMENT/ ASSOCIATION | WORK PHONE |
|---|---|---|---|
| | | | |

**LIST ALL FAMILY MEMBERS YOU WISH TO ENROLL**

Children between the ages of 19-25 residing off island must submit evidence of Full time student status to be eligible for coverage

| LAST NAME | FIRST NAME | MIDDLE INITIAL | RELATIONSHIP | SOCIAL SECURITY NO. | SEX M F | BIRTHDATE |
|---|---|---|---|---|---|---|
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |

**FOR OFFICE USE ONLY**

| ENROLLMENT | | CUSTOMER CARE | UNDERWRITING | CASHIER |
|---|---|---|---|---|
| Group No.: | | Received by: | | |
| Option | | Reviewed by: | | |
| Entered | | **MARKETING** | | |
| Eff. Date: | | Representative: | | |
| | | Reviewed by: | | |

The following information is requested regarding the health of all dependents including yourself, you wish to obtain health coverage for.

| FAMILY MEMBER | SEX M F | AGE | HEIGHT | WEIGHT |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

**SECTION A:** All questions must be checked [ × ] **Yes** or **No**. If answer is **Yes**, circle the appropriate condition(s).

| | | | Yes | No |
|---|---|---|---|---|
| 1. | | *Has anyone listed on this application ever received any professional medical advice or treatment for or had any symptoms pertaining to any of the following conditions?* | | |
| | a. | Brain or Nervous System: such as dizziness, fainting, headaches, seizure disorder, epilepsy, paralysis, muscular dystrophy, multiple sclerosis, stroke, cerebral palsy, polio or others? | ☐ | ☐ |
| | b. | Heart or Cardiovascular System: such as heart disease, chest pain, high or abnormal blood pressure, heart or valve problems, heart attack, heart murmur, rheumatic fever, palpitations, or others? | ☐ | ☐ |
| | c. | Circulatory System: such as varicose veins, peripheral vascular disease, phlebitis, blood clots, bleeding problems, blood disorder, anemia, or enlarged lymph nodes, or others? | ☐ | ☐ |
| | d. | Lungs or Respiratory System: such as asthma, reactive airway disease, bronchitis, hay fever, allergies, sinusitis, emphysema, tuberculosis, cystic fibrosis, chronic obstructive pulmonary disease or others? | ☐ | ☐ |
| | e. | Digestive System: such as mouth, tongue, esophagus or stomach problems, ulcer, gallbladder disorder, liver disease, cirrhosis, jaundice, cirrhosis, hepatitis, pancreatitis, colon, intestinal or rectal problems, bleeding, polyp, hemorrhoids, hernia, or others? | ☐ | ☐ |
| | f. | Urinary Tract: such as kidney, ureter, bladder, urethral problems, infections, stricture, stones or others? | ☐ | ☐ |
| | g. | **Male Reproductive System**: such as prostate problem, infertility, male breast problems, gynecomastia, syphilis, gonorrhea or other venereal disease or others? | ☐ | ☐ |
| | h. | **Female Reproductive System**: such as breast problem, breast implants, abnormal bleeding, amenorrhea, endometriosis, fibroid tumors, abnormal Pap test, problem of the ovaries and uterus, infertility, in-vitro fertilization, genital warts, syphilis or other venereal disease, or others? | ☐ | ☐ |
| | i. | Musculo-Skeletal System: such as neck, spine/back sprain, pain, injury, sciatica, herniated or bulging disc, or other problems, curvature of the spine, scoliosis, any problems of the joints, bones, muscle or tendon, arthritis, fractures/residual hardware,dislocation, carpal tunnel syndrome, physically handicapped, amputation, or others? | ☐ | ☐ |
| | j. | Metabolic System: such as diabetes, gout, goiter, thyroid or adrenal disorder, or growth hormone deficiencies or immune system disorder, such as lupus, Raynauds, acquired immune deficiency syndrome (AIDS), any other blood disorder, including evaluation for AZT therapy, or others? | ☐ | ☐ |
| 2. | | *Has anyone listed ever had a history of or incidence of the following:* | **Yes** | **No** |
| | a. | Skin Conditions: such as skin cancer, melanoma, psoriasis, warts, birthmarks, burns, severe acne, or others. | ☐ | ☐ |
| | b. | Disease or Problems of the Eyes or Sight, Ears or Hearing, Nose or Breathing, Throat or Swallowing: such as glaucoma, cataract, crossed eyes, detached retina, polyps, deviated nasal septum, problems with tonsils or adenoids, sleep apnea, or others? | ☐ | ☐ |
| | c. | Cancer, Tumor, Cysts, Leukemia, Hodgkins Disease, Lymphoma, or others? | ☐ | ☐ |
| | d. | Alcoholism, Drug Dependency or Substance Abuse? | ☐ | ☐ |
| | e. | Congenital Abnormalities, Birth Defects: such as Down's Syndrome, cleft lip or palate, club foot, developmental delay, mental retardation, or other neurological or physical abnormalities, or others? | ☐ | ☐ |

| | | | Yes | No |
|---|---|---|---|---|
| 3. | | *Has anyones listed received any counseling, professional advise or treatment for symptoms of depression, anxiety, panic attacks, nervousness, mental or emotional disorder, schizophrenia, behavorial problems, attention deficit disorder or for any other reasons?* | ☐ | ☐ |
| 4. | | *Has anyone listed ever had surgery such as cosmetic/reconstruction procedure/surgery (including breast implants or organ transplant surgery?* | ☐ | ☐ |
| 5. | | *Has anyone listed ever had abnormal laboratory results, x-rays, EKG, nerve condition, MRI scan, or CT scan?* | ☐ | ☐ |
| 6. | | *Does anyone listed previously or currently have a prosthesis, implants, or retained hardware?* | ☐ | ☐ |
| 7. | | *Has anyone listed every had a pregnancy resulting in cesarean section or is one anticipated?* | ☐ | ☐ |

8. *FOR FEMALE APPLICANTS ONLY* *FAMILY MEMBER*

a. When was your last menstrual period?

b. If pregnant, when is expected date of delivery

**SECTION B:** If you have answered **Yes** to any of the questions in SECTION A, give full details below. If additional space is necessary to provide complete information, please attach a sheet of paper.

| QUESTION NO. | FAMILY MEMBER | DIAGNOSIS | DATES OF TREATMENT(S) | NAME OF PHYSICIAN (CLINIC/HOSPITAL) |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

**SECTION C:** For each person listed, please provide details of visits to a physician clinic or hospital in the last 5 years.

| FAMILY MEMBER | DATE OF VISIT | REASON FOR EXAMINATION | FINDINGS | PHYSICIAN/CLINIC/HOSPITAL |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

**SECTION D:** Is anyone listed currently taking medication or have you taken any medication in the past 12 months? If **Yes**, please list below. ☐ Yes ☐ No

| FAMILY MEMBER | NAME OF MEDICATION AND CONDITION | DATES FROM/TO | PHYSICIAN |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

**SECTION E:** Please answer each question.

1. *Is anyone listed disabled, hospitalized or receiving medical care in the home at this time?* ☐ Yes ☐ No

| |
|---|
| FAMILY MEMBER(S) |
| EXPLANATION |

2. *Has anyone listed been advised to undergo further testing, treatment, organ transplant or surgery?* ☐ Yes ☐ No

| |
|---|
| FAMILY MEMBER(S) |
| EXPLANATION |

3. *Does anyone listed presently have any condition, illness or complications not mentioned previously?* ☐ Yes ☐ No

| |
|---|
| FAMILY MEMBER(S) |
| EXPLANATION |

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

| FAMILY MEMBER | PACKS/DAY | YEARS SMOKED | QUIT? IF YES, WHAT YEAR? |
|---|---|---|---|
| | | | |
| | | | |

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

| FAMILY MEMBER | DRINKS/WEEK | TYPE |
|---|---|---|
| | | |
| | | |

## SECTION F

1. *Has anyone listed ever had any previous health coverage? (including Medicare/Medicaid/MIP)* ☐ Yes ☐ No

| If Yes: Name of Insurance | Group | Individual | EFFECTIVE DATE | TERMINATION DATE |
|---|---|---|---|---|
| | ☐ | ☐ | | |
| Name of Insurance | Group | Individual | EFFECTIVE DATE | TERMINATION DATE |
| | ☐ | ☐ | | |

2. *Is anyone listed eligible to enroll in another health insurance plan such as COBRA, Medicare, or Medicaid? If Yes, please explain below.* ☐ Yes ☐ No

3. *Has anyone listed ever had health insurance coverage cancelled as a result of non-payment of premiums or fraud? If Yes, please explain below.* ☐ Yes ☐ No

4. *Has anyone listed ever had any application for health or life insurance declined, postponed, or restricted? If Yes, please explain below.* ☐ Yes ☐ No

   Family Member(s):

   Explanation:

5. *Is anyone listed currently enrolled in COBRA? If Yes, please explain below.* ☐ Yes ☐ No

   Explanation Date:

6. *Has anyone ever been enrolled in COBRA? If yes, please explain below.* ☐ Yes ☐ No

   A. When did your COBRA coverage expire?

   B. Explanation

## AUTHORIZATION

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

## AGREEMENT

I agree that I shall abide by the provisions of coverage of the Personal Plan Certificate 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 eligibile dependents may only be added within 30 days from becoming eligibile.

I understand that any claims asserted by me or my dependents against StayWell, its employees or agents, whether based in contract, tort, or otherwise (including professional liability) are subject to binding arbitration. I have read the brochure which contains the benefits, limitations and exclusions applicable to my health care plan. I understand that the coverage for which I am eligbile will be further explained, upon request, by a StayWell representative. I understand that StayWell has the right to request for additional documents as needed to determine eligibility.

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.

## NOTICE

Approval of this Application 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. I am in good health if any condition, disease, or change in health status occurs after you complete this Application but before the effective date, you must immediately update this Application by sending a written explanation to **StayWell, P.O. Box CZ, Hagatna, Guam 96932, Attn: Underwriting Department**. If you fail to provide this updated information, or if you provide any incorrect or incomplete answers on this Application or in future correspondence concerning this Application, your coverage and your family's coverage may be terminated at any time. I understand that any misrepresentation as to the presence or pre-existing impairment(s) or disease(s) or any medical conditions will void Health Care Benefits.

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

All applicants 18 and over must sign below.

| SIGNATURE OF APPLICANT OR LEGAL GUARDIAN | PRINT NAME | DATE OF BIRTH | DATE |
|---|---|---|---|
| SIGNATURE OF APPLICANT OR LEGAL GUARDIAN | PRINT NAME | DATE OF BIRTH | DATE |
| SIGNATURE OF APPLICANT OR LEGAL GUARDIAN | PRINT NAME | DATE OF BIRTH | DATE |
| SIGNATURE OF APPLICANT OR LEGAL GUARDIAN | PRINT NAME | DATE OF BIRTH | DATE |