StayWell Health Plan Eligibility Certificate

AFFIDAVIT

This form is to be completed by a certifying officer of the company before applicant(s) will be considered for enrollment.

Name of Company						
Employee Names	**Hire Date**	**Full or Part Time**	**Weekly Hours**	**Probation Period**		**Date of insurance eiligbility**
				Start	**End**	

INSTRUCTIONS:

This form must be returned with copies of the employee's two (2) most recent check stubs. All documents must be received by the StayWell Marketing office no later than the 6th of the month.

NOTE: **Falsification of information may result in the termination of the entire group. StayWell reserves the right to request additional information as needed.**

I certify that the information stated above and in all attached documentation is accurate.

PRINT NAME

TITLE

SIGNATURE

DATE

520 Route 8 Maite, Guam 96910