Application for Enrollment

COMMERCIAL GUAM ☐ COMMERCIAL CNMI ☐

StayWell INSURANCE

CHOOSE ONE MEDICAL PLAN:

☐ GOLD ☐ SILVER ASIAPACIFIC ☐ CW 100 ☐ OTHER

☐ GOLD12 ☐ 7030 ☐ CW 8020 _____

☐ SILVER ☐ BRONZE ☐ RCW8020

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.
MAILING ADDRESS			
SEX	MARITAL STATUS	DATE OF BIRTH (MM/DD/YY) / /	SOCIAL SECURITY NO.
HOME PHONE	WORK PHONE (INCLUDE EXT.)	OTHER CONTACT NO.	EMAIL ADDRESS
EMPLOYER (CONTRACT WORKER? YES OR NO)		DATE OF EMPLOYMENT	PROBATION PERIOD ☐ NONE ☐ 30 DAYS ☐ 60 DAYS ☐ 90 DAYS ☐ OTHER _____
SPOUSE'S NAME		SPOUSE'S EMPLOYER	SPOUSE'S CONTACT NO.

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

Name of Insurance	Name of Insured	Group or 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.	SOCIAL SECURITY NO.	BIRTHDATE	SEX M F
SPOUSE						

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 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 (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. 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. I understand that StayWell has the right to request for additional documents as needed to determine eligibility.

_____ EMPLOYEE'S SIGNATURE

_____ DATE SIGNED

FOR OFFICE USE ONLY:

ENROLLMENT		CUSTOMER CARE	MARKETING	NOTES
Group No.:		Received by:	Representative:	
Entered By:		Received date:		
Entered Date:		**UNDERWRITING**	Effective Date:	
Eff. Date:		Reviewed by:	Reviewed by:	
Member No.:		Received by:		