TakeCare℠
A Tan Holdings Company
P.O. Box 6578 Tamuning, Guam 96931

# NEXCOM
## Enrollment Form/Change Request Form

**1** Type of Request ▶ ☐ Initial Enrollment ☐ Change Request ☐ Add ☐ Cancel ☐ Delete ☐ Tier/Coverage ☐ Update

**2** Division ▼ **3** Date Employed ▼ / /

**4** Medical Coverage ▼
☐ Premier 20-100-10 $100 HCP

**5** Dental Coverage ▼
Dental plan not offered by TakeCare

**6** Enrollment Tier ▼
☐ Employee Only ☐ Employee + One ☐ Employee + Two or More

**7** Employee Name ▼ LAST NAME FIRST NAME M.I. **8** Date of Birth ▼ / /

**9** Gender ▼ ☐ M ☐ F **10** Social Security No. ▼ **11** Employee Title ▼ Employee ID No. ▼ **12** Marital Status ▼

**13** Mailing Address ▼ VILLAGE STATE ZIP CODE

**14** Home Telephone No. ▼ **15** Work Telephone No. ▼ **16** Mobile Phone No. ▼ **17** Email Address ▼

**18** Please list enrollees below starting with yourself, your spouse/common law (if any), and then any children to be covered by the Health Plan. Official supporting documentation will be required to enroll Eligible Dependents, including your spouse/common law and children, for the purpose of verifying eligibility. Specifiy the relationship of each dependent to you (for example: husband, wife, common law, son, daughter, etc.). Please note that certain dependent relationships may not be recognized by your Group or the Health Plan. **PLEASE PRINT CLEARLY.**

| NAME: Last | First | M.I. | RELATION TO YOU* (spouse, son, daughter, etc.) | IS DEPENDENT RESIDING OFF ISLAND? Yes/No | Add/ Delete | Gender | SSN | DOB | FOR TAKECARE USE |
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**To help us coordinate your care, please answer the following questions.**

**19** Does anyone, listed above, have other health insurance in addition to TakeCare? ☐ YES ☐ NO If YES, please fill out below.
Member Name(s): _____ Other Health insurance: _____
Name of Policy Holder: _____ Policy No.: _____ Effective Date: _____

**20** Does anyone, listed above, have MEDICARE coverage? ☐ YES ☐ NO If YES, please fill in section below.
(1) Member Name: _____ MEDICARE No.: _____
PART A - Effective Date: _____ PART B - Effective Date: _____ PART D - Effective Date: _____
(2) Member Name: _____ MEDICARE No.: _____
☐ PART A - Effective Date: _____ ☐ PART B - Effective Date: _____ ☐ PART D - Effective Date: _____

**21** Please provide information if you have any ongoing care (optional):
_____

***COMMERCIAL MEDICAL LOCK-IN PROVISION:** Medical Coverage cancellation will only be allowed during open enrollment

**22 MISCELLANEOUS CHANGES ▼**

(Subscribers who add or delete dependent(s) must meet a HIPAA Qualifying Event. CLASS CHANGES MUST BE DIRECTLY REPORTED TO YOUR PERSONNEL DEPARTMENT)

☐ **Medical** Change from: _____ to _____ Effective: _____

(PLEASE ATTACH OFFICIAL DOCUMENTATION, i.e. MARRIAGE/BIRTH CERTIFICATE, COURT ORDER TO SUPPORT NAME CHANGE)

☐ Subsrciber ☐ Dependent Name Change from: _____ to _____

☐ Other (Specify): _____ from _____ to _____ Effective: _____

**23 CANCELLATION OF COVERAGE (For Subscribers Only): ▼**

☐ Medical Coverage Effective: _____
*Subscriber's medical coverage cancellation will only be allowed during open enrollment or when you resign/terminate your employment.

**REASON FOR CANCELLATION**
☐ Termination / Resignation from employment

**You accept the health insurance coverage provide through this employer by signing on the space provided below. By signing below, you have read the subscriber agreement section and temporary ID form and deductible plan insturctions on the back of this enrollment form.**

**24** Employee Signature _____ Date _____

**25 GROUP VALIDATION AND EFFECTIVE DATE REQUIRED:**
Employer Group Representative Signature _____ Date _____
▶ Effective Date ▶ / /

**For TakeCare Use Only**

GROUP ID ▶ SG ID ▶ CLASS ▶ SCREEN ▶
MED ID ▶ ENTER ▶ CARDS ▶ VERIFY ▶ SUB ID ▶