

P.O. Box 6578 Tamuning, Guam 96931

1 Group / Employer Name ▼ **2** Date Employed ▼ / /

3 Medical Coverage ▶
 Guam **CNMI** **Palau**
 Premier _____ Premier _____ Premier _____
 Premier FHP Contract Worker Basic
 Premier HDHP

4 Medical Class ▶ **Employee Only** **Employee and Spouse**
 Employee & 1 Child **Employee & Children**
 Employee with Spouse & Children

5 Dental Coverage ▶ **Dental**

6 Dental Class ▶ **Employee Only** **Employee and Spouse**
 Employee & 1 Child **Employee & Children**
 Employee with Spouse & Children

7 Employee Name ▼ LAST NAME FIRST NAME M.I. **8** Social Security No. ▼

9 Gender ▼ M F **10** Date of Birth ▼ / / **11** Employee Title ▼ Employee ID No. ▼

12 Mailing Address ▼ VILLAGE STATE ZIP CODE

13 Home Telephone No. ▼ **14** Work Telephone No. ▼ Email Address ▼

15 Please list enrollees below starting with yourself, your spouse (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 and children, for the purpose of verifying eligibility. Specify the relationship of each dependent to you (for example: husband, wife, 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.)	SSN	DOB	ENROLL IN MED or DEN?	PRIMARY CARE MEDICAL PHYSICIAN	FOR TAKECARE USE
			SELF		/ /	<input type="checkbox"/> MED <input type="checkbox"/> DEN		
					/ /	<input type="checkbox"/> MED <input type="checkbox"/> DEN		
					/ /	<input type="checkbox"/> MED <input type="checkbox"/> DEN		
					/ /	<input type="checkbox"/> MED <input type="checkbox"/> DEN		
					/ /	<input type="checkbox"/> MED <input type="checkbox"/> DEN		
					/ /	<input type="checkbox"/> MED <input type="checkbox"/> DEN		
					/ /	<input type="checkbox"/> MED <input type="checkbox"/> DEN		

To help us coordinate your care, please answer the following questions. Any omission of information or intentional misrepresentation in answering the following questions of you and your dependents may result in denial of benefits and the termination of your coverage.

16 Is anyone, listed above, in the hospital? YES NO If YES, who? _____

17 Is anyone, listed above, receiving ongoing medical care for a chronic illness/condition? YES NO
 If YES, whom and for what illness? _____

18 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: _____

19 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: _____

You accept the health insurance coverage provided 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 instructions on the back of this enrollment form.

20 Employee Signature _____ Date _____

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

For TakeCare Use Only

MEDICAL TERM ▶ [] DENTAL TERM ▶ [] GROUP ID ▶ [] SG ID ▶ [] SCREEN ▶ []
 MED ID ▶ [] DEN ID ▶ [] ENTER ▶ [] CARDS ▶ [] VERIFY ▶ [] SUB ID ▶ []

PLEASE READ CAREFULLY AND ACKNOWLEDGE BELOW

THIS IS YOUR TEMPORARY ID FORM This form will serve as a temporary identification. It is valid for thirty (30) days from the effective date of coverage. However, in order to be valid, the form must be signed by you and your Group HR/Personnel Representative, as well as, be approved and accepted by TakeCare. Please keep it with you and present it each time you require services. You will be personally responsible for the cost of services if you are not eligible or the services are not covered. If you do not receive your dependent's membership card within thirty (30) days after you become eligible, please call our **Customer Service** number at GUAM (671) 647.3526 ; CNMI (670) 235.7687 ; PALAU (680) 488.4715.

FOR MEMBERS ENROLLED IN PLANS WITH DEDUCTIBLES

- 1 Subscribers with a deductible on their medical plan will receive a temporary ID card until their deductibles are met.
- 2 Members can present this temporary ID card during visits to their doctor or lab to receive TakeCare contracted rates on health services received.
- 3 Only claims from visits to doctors, labs or pharmacies within the TakeCare network will be accumulated in full towards deductibles. Any claims for visits to non-participating doctors, labs or pharmacies will be accumulated at 70% of eligible charges.
- 4 Full payment of medical services is the responsibility of the member at the time of the doctor, lab or pharmacy visit until the deductibles are met.
- 5 A TakeCare Deductible Claim Form should be filled out immediately and kept safe to ensure accurate and complete information on all doctor, lab or pharmacy visits.
- 6 When the total payments of an individual member's medical visits equals or surpasses their plan deductible amount, they should submit Deductible Claim Form(s) and accompanying receipts and invoices to the TakeCare Customer Service department.
- 7 After review and confirmation that deductibles have been met, a new member ID card will be issued via mail and medical plan benefits as specified in schedule of benefits will be in effect.

SUBSCRIBER AGREEMENT SECTION "I hereby authorize my employer to deduct from my earnings any employee contribution required to cover my share of the premium for group benefits for which I am eligible. I agree that I shall abide by the provisions of coverage in the TakeCare Group Policy 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 thirtyone (31) days from becoming eligible or during the open enrollment period of my group. I have read and understand the eligibility requirements and attest that all my dependents and I meet these requirements. I agree to provide TakeCare all documents necessary to support eligibility. I understand that TakeCare has the right to request required documents at anytime after enrollment. I understand that failure to submit required documents would result in a loss of coverage or services at the discretion of TakeCare. Should this occur, I understand and agree that I will be responsible for the cost of all healthcare services provided to me and/or my dependents. I understand that providing coverage and services do not constitute acceptance of my eligibility by TakeCare until I provide all documents requested by TakeCare to provide my dependents' and my eligibility for coverage. I also give my consent to TakeCare or its designee to access and use my medical records or the medical records of my dependents to assure correct and timely medical diagnosis and for purposes, as required by law, of Utilization Review, Quality Assurance, surveys and processing of claims. I understand that any claims asserted by my dependents or me against TakeCare, its employees or agents, whether based in contract, tort or otherwise for professional liability, are subject to binding arbitration. I have received a copy of the TakeCare member handbook that contains the benefits, limitations and exclusions applicable to my healthcare plan. 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 TakeCare will charge an additional service, collection, or attorneys fee for the collection of any amounts owed to TakeCare or the processing of a returned check for services rendered or products purchased on behalf of members covered by this plan. I also give my consent to TakeCare or its designee to request and obtain Medicare eligibility information regarding all members covered by my plan."

Employee's Initials _____ Date _____