Application for Enrollment

COMMERCIAL GUAM ■ COMMERCIAL CNMI ■

All fields and questions must be answered. If not applicable, please write N/A. Any changes made to this form must be initialed.

CHOOSE ONE MEDICAL PLAN				CHOOSE ONE OPTION	CHOOSE ONE CLASS
☐ GOLD	☐ SILVER ASIA PACIFIC	☐ CW 100	☐ OTHER	☐ MEDICAL ONLY	☐ CLASS I — Employee Only
☐ GOLD12	☐ 7030	☐ CW 8020	________	☐ MEDICAL & DENTAL	☐ CLASS II — Employee + 1
☐ SILVER	☐ BRONZE	☐ RCW8020			☐ CLASS III — Employee + 2 or More

LAST NAME		FIRST NAME	M.I.
MAILING ADDRESS (Street, City, State, Zip Code)			
GENDER	MARITAL STATUS ☐ Single/Widowed ☐ Married ☐ Common Law/Domestic Partner ☐ Divorced	BIRTHDATE (MM/DD/YY)	
EMAIL ADDRESS		SOCIAL SECURITY NO.	
HOME PHONE	WORK PHONE (INCL. EXT.)	OTHER CONTACT NO.	
EMPLOYER		JOB TITLE	
DATE OF EMPLOYMENT (MM/DD/YY)	PROBATION PERIOD ☐ NONE ☐ 30 DAYS ☐ 60 DAYS ☐ 90 DAYS ☐ OTHER ________	CONTRACT WORKER ☐ YES ☐ NO	
SPOUSE'S NAME	SPOUSE'S EMPLOYER	SPOUSE'S CONTACT NO.	

LIST ALL MEDICAL INSURANCE COVERAGE WITHIN THE LAST 12 MONTHS (Including Medicare/Medicaid/MIP)
Attach additional sheets if necessary

Name of Insurance	Name of Insured	Group	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.
1. SPOUSE	SOCIAL SECURITY NO.	BIRTHDATE (MM/DD/YY)	GENDER	EMAIL ADDRESS	

RELATIONSHIP	LAST NAME		FIRST NAME		M.I.
2.________	SOCIAL SECURITY NO.	BIRTHDATE (MM/DD/YY)	GENDER	EMAIL ADDRESS (if 18 years old or older)	

RELATIONSHIP	LAST NAME		FIRST NAME		M.I.
3.________	SOCIAL SECURITY NO.	BIRTHDATE (MM/DD/YY)	GENDER	EMAIL ADDRESS (if 18 years old or older)	

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. I understand and agree that I may be responsible for the cost of all health care provided to me and my dependents should a loss of coverage occur.

By signing below, my dependents and I agree to receive marketing and promotional material from StayWell Insurance to the contact information provided. I understand that I/we have the right to opt-out from receiving such materials at any time, and may do so by checking the box below or by emailing marketing@staywellguam.com.

☐ I/We prefer not to receive marketing and promotional material from StayWell Insurance

________________________ ________________
APPLICANT'S SIGNATURE DATE SIGNED

FOR INTERNAL USE ONLY			
ENROLLMENT	**CUSTOMER CARE**	**MARKETING**	**NOTES**
Group No.:	Received by:	Representative:	
Entered By:	Received date:		
Entered Date:	**UNDERWRITING**	Manager:	
Effective Date:	Reviewed by:	Reviewed by:	
Member No.:	Received by:	Effective Date:	