Government of Guam
Enrollment/Change of Status Form

TO AVOID POTENTIAL ERRORS, PLEASE DO NOT SUBMIT A FORM IF NO CHANGES ARE BEING MADE

1 **Department/Agency:** _____

2 ☐ **New Enrollment/Rehire:** I am a new member (please indicate your medical and dental enrollment option)
If a rehire, please enter your prior Aetna WID#

☐ **Terminate Coverage:** Applicable only during Open Enrollment or upon employment termination

☐ **Change of Status:** Please indicate the type of change and make the necessary selections or updates in the required sections

- ☐ **Add Dependent:** List dependent to be added and attach any supporting documents (verify class)
- ☐ **Delete Dependent:** List dependent(s) below to be deleted (verify class)
- ☐ **Plan Change:** Indicate new plan election(s)
- ☐ **Class Change:** Indicate your new Class Option and attach any supporting documents
- ☐ **Update Information:** Indicate new information such as address or telephone changes
- ☐ **Name Change:** Indicate your new name and attach supporting documents

3 **Employee/Retiree/Survivor Information:** ☐ Active Employee ☐ DB Retirement Fund (Old Plan) ☐ DC Retirement Fund (New Plan)

Aetna WID (if existing/rehire):		Social Security No.:
Last Name:	First Name:	M.I.:
Sex: ☐ M ☐ F	Birth Date (MM/DD/YYYY):	Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widow
Mailing Address:		Apt./Unit:
City:	State:	Postal Code:
Primary Phone:		Email Address:

4 **Medical Plan:** ☐ PPO1500 ☐ HSA2000

- ☐ **Class I:** Subscriber Only
- ☐ **Class II:** Subscriber + Spouse
- ☐ **Class III:** Subscriber + Child/ren
- ☐ **Class IV:** Subscriber + Spouse & Child/ren

Retiree Supplemental Plan

Medicare A & B Primary, must Enroll

- ☐ **Class I:** RSP Subcriber Only
- ☐ **Class II:** RSP Subscriber + RSP Spouse

RSP Dependents Not Medicare Enrolled

PPO1500 ☐ HSA2000 ☐

- ☐ **Class II:** + Non Medicare Spouse
- ☐ **Class III:** + Non Medicare Child/ren
- ☐ **Class IV a:** + RSP Spouse & Non Medicare Child/ren
- ☐ **Class IV b:** + Non Medicare Spouse & Child/ren

5 **Do you want Dental?** ☐ Yes ☐ No

Personal Information

Aetna ID Number: W

Last Name: First Name:

Last Four Digitals Of Social Security No.:

6 **Dependent Information** (Spouse and dependent children up to 26 years of age)

Last Name	First Name	M.I.	Social Security No.	Sex (M/F)	Birth Date	Relationship

7 **Other Insurance:** ☐ I have, or my dependents have or will have health coverage with another carrier

Name of the Insured	Insurance Carrier	Effective Date

8 **If Medicare:**

	Part A Number and Effective Date	Part B Number and Effective Date
Self:		
Spouse:		

Acknowledgments – Signatures required: I have read and agree to the terms of the authorization on page 2 of this Enrollment/Change Request form. I understand that, in the event I fail to sign this form within 31 days after the above transaction request or that for any reason Aetna does not receive notice of the above transaction within a reasonable time following the event, me and my and dependents' eligibility may be affected. I authorize deductions of the required contributions for the plan elections I have selected. I understand that my elections can only be changed during the next annual open enrollment period or if I have a qualifying status change during the year and understand that I must request such changes within 31 calendar days of the qualifying event. You may elect to use an electronic form of signature on this enrollment/change request form confirming your verification and declaration to the details given above. For the avoidance of doubt, such electronic signature will be valid and binding as if you had provided your original signature. We may rely on such electronic signature as a binding verification and declaration confirming that the information above is accurate and not misleading in all respects. The Employer affirms that it has conducted the appropriate validation regarding the authenticity of the employee's signature (electronic or otherwise) and the source of the submitted form.

9 Employee Signature: Date:

For employer use only

GovGuam Signature:		Date:	Effective Date (MM/DD/YYYY)
Supporting documents	☐ Birth Certificate	☐ Military Orders	Pay period ending:
	☐ Marriage Certificate	☐ Common Law Affidavit	
	☐ Court Order	☐ Other	

Authorization/Declaration of Applicant(s):

Disclosure of Healthcare Information	My spouse, competent adult dependents, and I (those who are applying for coverage under this Application) authorize any physician, healthcare professional, hospital, other healthcare institution ("Providers"), and my employer to disclose, to the extent allowed by applicable law, to Aetna or an affiliated entity ("Aetna"), information concerning the medical history, services, supplies, or treatment provided to anyone listed on this Application, including those services involving dental, behavioral health, substance abuse and HIV/AIDS ("healthcare information").
Redisclosure of Healthcare Information	I confirm and agree that personal information and/or healthcare information collected or held by Aetna, whether contained in this Application form or otherwise obtained, may be disclosed worldwide to my employer, Aetna affiliates, Providers, payors, other insurers, third party administrators, vendors, consultants, and governmental authorities with appropriate jurisdiction, when necessary for care or treatment, payment for services, and activities related to the operation of my health plan.
Purpose of Disclosure/ Redisclosure	I understand that Aetna may rely on such information to: 1) underwrite this application for coverage, make eligibility, risk rating, policy issuance and enrollment determinations for all of the applicants; 2) administer claims and determine or fulfill responsibility for coverage and provisions of benefits; 3) administer coverage; 4) conduct other insurance operations, like marketing and publicity, according to applicable laws and regulations.
Authorization of Enrollee	I have discussed the terms of this authorization with my spouse and competent adult dependents, and I have obtained their consent to the release of their healthcare information pursuant to this authorization. I understand that I may decline to provide Aetna with consent to process my personal or healthcare information; however, this may result in declination of coverage.
Covered Member's Rights	I understand that I may review and offer corrections to my personal or healthcare information, to the extent allowed by law, receive a copy of this authorization upon request, and that a photocopy is as valid as the original; and I may revoke this authorization at any time, to the extent it has not been relied upon by Aetna or other party. I also have the right to opt out of any direct marketing campaigns.
Duration of Authorization	This authorization shall remain valid for the term of this coverage or for as long as allowed by law.
Payroll Deductions and Other Payments	I request the coverage which I have indicated and for which I am eligible. I authorize deductions from my earnings for any contributions required for healthcare coverage, and I agree to make any necessary payments as required for coverage.
Independent Contractors	I acknowledge that Aetna's participating providers are independent contractors and are not agents or employees or Aetna or any affiliated Aetna Entity.

Misrepresentations: Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.