GOVERNMENT OF GUAM

Self Insured Dental Program Enrollment/Change of Status Form

Administered by: NetCare Life & Health Insurance

Employment Status: ☐ Active Employee | ☐ Retiree ☐ Survivor of Retiree ☐ DC Retirement Plan ☐ DB Retirement Plan Agency ________ GGRF

First Name	M.I.	Last Name

GovGuam Agency/Department	Eff. Date of Coverage	Date of Employment	Social Security No.

Mailing Address	City	State	Zip

Home Phone	Work Phone & Ext.	Cell Phone / Other Phone	Date of Birth	Sex	Marital Status

E-mail Address

☐ **New Enrollee -** New enrollment for Employee, Retiree, or Survivor

☐ **Terminate Coverage -** You may only terminate during Open Enrollment or upon Termination of Employment

☐ **Change Of Status -** You are making changes to your current policy

☐ Add Dependent(s) ☐ Delete Dependent(s) ☐ Update Information ☐ Class Change

Deduction Class

☐ **Class I** - Employee, Retiree or Survivor only

☐ **Class II** - Employee, Retiree or Survivor with Spouse/Domestic Partner

☐ **Class III** - Employee, Retiree or Survivor with Child(ren)

☐ **Class IV** - Employee, Retiree or Survivor with Spouse/ Domestic Partner and Child(ren)

Dependent Information Spouse/Domestic Partner & dependent children up to 26 years of age.

Only fill out Address/Email information below for Dependent(s) opting to receive correspondence separately.

Last Name	First Name & M.I.	Relation to Subscriber	Social Security Number	Sex	Date of Birth
Mailing Address			Email Address		
Last Name	First Name & M.I.	Relation to Subscriber	Social Security Number	Sex	Date of Birth
Mailing Address			Email Address		
Last Name	First Name & M.I.	Relation to Subscriber	Social Security Number	Sex	Date of Birth
Mailing Address			Email Address		
Last Name	First Name & M.I.	Relation to Subscriber	Social Security Number	Sex	Date of Birth
Mailing Address			Email Address		
Last Name	First Name & M.I.	Relation to Subscriber	Social Security Number	Sex	Date of Birth
Mailing Address			Email Address		
Last Name	First Name & M.I.	Relation to Subscriber	Social Security Number	Sex	Date of Birth
Mailing Address			Email Address		
Last Name	First Name & M.I.	Relation to Subscriber	Social Security Number	Sex	Date of Birth
Mailing Address			Email Address		

Other Coverage If you or your dependent(s) have dental coverage elsewhere, please complete this section for coordination of benefits with your NetCare Plan.

Last Name, First Name & M.I.	Insurance Carrier Name	Relation to Subscriber	Policy Number	Eff. Date
Last Name, First Name & M.I.	Insurance Carrier Name	Relation to Subscriber	Policy Number	Eff. Date
Last Name, First Name & M.I.	Insurance Carrier Name	Relation to Subscriber	Policy Number	Eff. Date
Last Name, First Name & M.I.	Insurance Carrier Name	Relation to Subscriber	Policy Number	Eff. Date

I agree that I shall abide by the provisions of coverage in the policy under which I am enrolled. I have read and understand the eligibility requirements and attest that I and all dependents meet these requirements. I understand that it is my responsibility to report any changes in the eligibility of my dependents. I understand that newly eligible dependents, to include legal guardians, may only be added within 31 days from becoming eligible or during Open Enrollment period. I understand that NetCare Life & Health Insurance Co. (NetCare) has the right to request required documents at any time and failure to submit these documents may result in a loss of coverage or service at the discretion of NetCare Life & Health Insurance Co. Should this occur, I understand and agree I may be responsible for the cost of all health care provided to me and my dependents. I understand that the providing of coverage and service does not constitute acceptance of eligibility by NetCare Life & Health Insurance Co. until eligibility for coverage has been proven. I further understand that any claims asserted by myself or my dependents against NetCare or any provider, whether based in tort, contract or otherwise (including professional liability) are subject to binding arbitration. Fraud Warning Notice: Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits a request for enrollment, or files a claim containing or false or depictive statement is guilty of insurance fraud.

Signature of Employee **Date Signed**

Distribution: White=NetCare Yellow=Personnel Pink=Payroll Gold=Member

For Official Use Only:

Date: ________ Pay Period Ending: ________

Supporting Docs: ________ Date & Time Recieved: ________

Validated by: ________ Signature: ________