GOVERNMENT OF GUAM

Self Insured Dental Program Enrollment/Change of Status Form

Administered by: NetCare Life & Health Insurance

Status: ☐ Active Employee ☐ Retiree ☐ Survivor of Retiree ☐ DB Retirement Plan ☐ DC Retirement Plan GGRF ____ Agency ____

First Name	M.I.	Last Name	
GovGuam Agency/Department	**Eff. Date of Coverage**	**Date of Hire or Retirement**	**Social Security No.**
Mailing Address	**City**	**State**	**Zip**

Home Phone	Work Phone & Ext.	Cell Phone / Other Phone	Date of Birth	Sex ☐ M ☐ F ☐ X (unspecified)	Marital Status

E-mail Address

Enrollment Type	Change of Status: Check all that applies	Termination/Cancellation
☐ New Employee	☐ Add/Delete Dependent	☐ Date of Separation: 8/27/26
☐ Retiree/Survivor	☐ Class Change: From ____ to ____	☐ Retirement Date: 8/27/26
☐ Open Enrollment	☐ Qualifying Event (QE) & Date: ____	☐ Date of Death: 8/27/26
☐ Qualifying Event	☐ Transfer : From ____ to ____	☐ Non-Payment: 8/27/26
	☐ Update Information	☐ Other: 8/27/26
	Supporting documents must be submitted within 31 days from QE	*Supporting documents must be submitted within 31 days from QE*

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 ○ add ○ delete	First Name & M.I.	Relation to Subscriber	Social Security Number	Sex	Date of Birth
Mailing Address			Email Address		
Last Name ○ add ○ delete	First Name & M.I.	Relation to Subscriber	Social Security Number	Sex	Date of Birth
Mailing Address			Email Address		
Last Name ○ add ○ delete	First Name & M.I.	Relation to Subscriber	Social Security Number	Sex	Date of Birth
Mailing Address			Email Address		
Last Name ○ add ○ delete	First Name & M.I.	Relation to Subscriber	Social Security Number	Sex	Date of Birth
Mailing Address			Email Address		
Last Name ○ add ○ delete	First Name & M.I.	Relation to Subscriber	Social Security Number	Sex	Date of Birth
Mailing Address			Email Address		
Last Name ○ add ○ delete	First Name & M.I.	Relation to Subscriber	Social Security Number	Sex	Date of Birth
Mailing Address			Email Address		
Last Name ○ add ○ delete	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 agree that I will pay the premium, including my employer's portion, for any periods where I am on Leave Without Pay (LWOP) directly to Department of Administration. I hereby authorize GovGuam to deduct the required cost for this program and acknowledge that I am responsible for ensuring the accuracy of these deductions. I understand that failure to make the necessary premium payments may result in termination of coverage without notice. Any unpaid premiums or claims will remain my responsibility, and I will not be eligible to re-enroll until all outstanding obligations have been fully satisfied. Once all obligations are cleared, re-enrollment will only be permitted during the Open Enrollment period. I acknowledgeI 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 GovGuam Member **Date**

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

For Official Use Only: ☐ First Ded ☐ Last Ded

Eff. Date: ____ Pay Period Ending: ____

Supporting Docs: ____ Date & Time Recieved: ____

Validated by: ____ Signature: ____

Form: GGEA 083126