



GOVERNMENT OF GUAM

Self Insured Dental Program Enrollment/Change of Status Form

Administered by:



Employment Status: Active Employee | Retiree | Survivor of Retiree | DC Retirement Plan | Agency _____
 DB Retirement Plan | 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 M F X (unspecified) | 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 III** - Employee, Retiree or Survivor with Child(ren)
- Class II** - Employee, Retiree or Survivor with Spouse/Domestic Partner | **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 |
|------------------------------|------------------------|------------------------|---------------|-----------|
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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 deceptive 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 Received: _____
 Validated by: _____ Signature: _____