CALVO'S SelectCare HEALTH PLANS

Medical Enrollment / Change of Status Form

Government of Guam

Employment Status: ☐ Active Employee ☐ Retiree ☐ Survivor of Retiree ☐ DC Retirement Plan ☐ DB Retirement Plan

First Name	M.I.	Last Name

GovGuam Agency/Department	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 -** Check ✓ this item if you are a NEW ENROLLEE.

☐ **Terminate Coverage -** You may only terminate your coverage during the Open Enrollment Period or upon Termination of Employment.

☐ **Change Of Status -** Make appropriate checks ✓ to the items below.

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

Health Plan Choice

☐ **HSA 2000** (Single Ded. is $2,000 / Family Ded. is $4,000.)

☐ **PPO 1500** (Single Ded. is $1,500 / Family Ded. is $3,000.)

☐ **Retiree Supplemental Plan (RSP)** (Must be enrolled in Medicare A and B and you must fill out "Other Insurance" below)

Deduction Class for HSA2000 AND PPO1500 Plans

☐ **Class I** Subscriber Only
☐ **Class II** Subscriber + Spouse/Domestic Partner
☐ **Class III** Subscriber + Child(ren)
☐ **Class IV** Subscriber + Spouse/Dom. Partner & Child(ren)

Deduction Class for RSP

Please elect a plan for non-medicare dependents if applicable: ☐ **HSA2000** ☐ **PPO1500**

☐ **Class I** RSP Subscriber Only
☐ **Class II** RSP Subscriber + RSP Spouse/Domestic Partner
☐ **Class IIb** RSP Subscriber + Non Medicare Spouse/Dom. Partner
☐ **Class III** RSP Subscriber + Non Medicare Child(ren)
☐ **Class IVa** RSP Subscriber + RSP Spouse/Dom. Partner + Non Medicare Child(ren)
☐ **Class IVb** RSP Subscriber + Non Medicare Spouse/Dom. Partner & 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 Insurance

Do you or will you or any of your covered dependents have other health coverage?
If "Yes", please indicate which other coverage will apply and the effective date of such coverage.

Person with Dual Health Insurance Coverage	Medicare Part A	Medicare Part B	Medicare Part D	Medicaid	Other Insurance Carrier	Medical	Dental	Effective 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 further understand that newly eligible dependents may only be added within 31 days from becoming eligible or during an Open Enrollment period for my group. I understand that **Calvo's SelectCare** 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 **Calvo's SelectCare**. 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 **Calvo's SelectCare** until eligibility for coverage has been proven.

I authorize any Medical/Healthcare Provider or Facility to give **Calvo's SelectCare** information concerning the medical history, prescription utilization history, services or treatment provided to anyone I have enrolled on this form, including any Mental Health, Substance Abuse and HIV/AIDS information. I further authorize **Calvo's SelectCare** to use such information and to disclose such information to affiliates, other Providers, payors, other insurers, third party administrators, vendors, consultants and government authorities with jurisdiction when as deemed necessary by **Calvo's SelectCare** for my care or treatment, payment of services, the operation of my health plan, or to conduct related activities. I have discussed the terms of this authorization with my spouse and competent adult dependents and I have obtained their consent to those terms. This authorization will remain valid for the term of the coverage and so long thereafter to finalize the administration of any remaining open claims. I understand that I am entitled to receive a copy of this authorization and that a photocopy is as valid as the original. I have read the benefit brochure and my questions pertaining to the **Calvo's SelectCare** Plan have been answered satisfactorily and will be further explained upon my request. I hereby authorize my employer to deduct any required cost for this program. 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 Calvo's SelectCare.

For Official Use Only:

Date: ____________ Pay Period Ending: ____________

Supporting Docs: ____________ Signature: ____________

Signature of Employee **Date Signed**

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