

101 Agana Shopping Center, Agana, Guam 96910 • Tel:(671) 477-8613, 8616, 7500, 8150

## GROUP CHANGE APPLICATION

Cash Name	Enrollment Change	Group Name			Group Number							
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APPROVED BY (GROUP ADMIN) DATE	EMPLOYER SIGNATURE			DATE								
			DATE									

Employee Name:			Date :						
Heigh	nt:(in ft.) nt:(in lbs.)							_	
	ealth Statement								
1.	1. Have you or any dependent been advised, diagnosed or treated for any of the following conditions? (Circle conditions to which				Spouse Yes No		Child(ren) Yes No		
	"yes" answer applies)  a. Disorders of the eye, ear, nose, or throat?								
	<ul><li>b. Hepatitis, intestinal bleeding, ulcer or any disease or disorder of the stomach, liver or kidney?</li><li>c. Lungs or respiratory disorders including bronchitis,</li></ul>								
	emphysema, asthma, pneumonia or allergies?  d. Disorders of the bone, joint, back, neck problems, arthritis								
	deformity or amputation? e. Brain, or neurological disorders, stroke, paralysis, seizures,								
	or multiple sclerosis?  f. Cancer, tumor, cyst, polyps, growths or skin disorder of any kind, benign or malignant?  g. Chest pain, heart attack, murmur, palpitation, rheumatic								
	fever or any disorder of the heart, blood or blood vessels?  h. Diabetes, gout, thyroid or any other gland disorder?  i. Epilepsy, nervous breakdown, Alzheimer's disease								
	Parkinson's disease?  j. Disorders of the reproductive system, Hemorrhoids, rectal								
	polyps, breast, or prostrate?  k. High blood pressure? If yes, state latest reading  l. Acquired immune deficiency syndrome (AIDS), AID			8					
	related complex (ARC), or (HIV)?  m. Sexually transmitted diseases (S.T.D.)	8							
2.	Have you or any dependent:     a. Been examined, treated or received any consultation by any physician or practitioner in the last 5 years?			_					
	b. Ever been treated or ever received consultation for alcohol or drug abuse?			_					
ar	c. Received counseling for any psychological disorder, anxiety, depression, hyperactivity, eating, or sleeping disorders?	_							
3. Are you or any dependent: a. Currently pregnant? If yes, how many months? b. Ever been pregnant? If yes, how many times? c. Ever been diagnosed or treated for any abnormal conditions of the female organs, menstrual periods, or									
e	experienced complications during pregnancy?								
4.	, , , , , , , , , , , , , , , , , , ,								
Have you been absent from work for 2 or more consecutive weeks due to illness or injury?									
6. Other than those identified above, have you or any dependent had, or been advised to have, currently contemplating medical attention, treatment or surgery of any kind?			_				-		

**Declaration**: I hereby represent and agree that all the answers and statements in this application are full, complete, and true, to the best of my knowledge and believe and understand that the said answers and statements form the basis upon which insurance will be made effective.

Continue to next page.

If you answered "Yes" to any of the health questions, please explain below. O# Individual Name Type of condition, treatment Type of Date Current Physician's Name / medication & Diagnosed Clinic & Address Status dosage I understand that to be eligible for the insurance applied for the foregoing representations must be true to the best of my knowledge and shall, in the absence of fraud, be deemed representations and not warranties, and if same not be true, that I am not eligible for insurance for which application made and the Company's liability is limited to a return of the premium. AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION IN CONNECTION WITH ELIGIBILITY FOR GROUP INSURANCE. To all providers of medical or hospital service plans, prepaid health plans, employers, group policyholders contract holders. For purposes of determining eligibility for insurance, and eligibility for benefits under an existing policy, I authorize you to furnish NetCare Life & Health Insurance Company and its re-insurers or its representatives performing business or legal functions, any information available about the medical history, condition, and treatment for myself, or the Dependents named in this Application. I authorize NetCare Life & Health Insurance Company and its re-insurers to use such information and to re-disclose such information to any attending physician for treatment purposed, and when necessary, to inform the activities, to any person who has an authorization specifically permitting the re-disclosure and as may be permitted or required by law. I hereby reserve the right to ask and receive a copy of this authorization form.. Employee Signature Date Witness