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

GROUP CHANGE APPLICATION

Enrollment Change	Group Name		Group Number
Last Name	First Name	Middle Initial	Social Security Number
Reason for change			
1.____ DELETE EMPLOYEE		EFFECTIVE DATE OF DELETION:	
2A.____CHANGE IN ANNUAL SALARY (if salary plan)			
FROM	TO	EFFECTIVE DATE OF CHANGE:	
2B.____ CHANGE IN AMOUNT OF COVERAGE (if class plan)			
FROM	TO	EFFECTIVE DATE OF CHANGE:	
3.____DELETE SUPPLEMENTAL ADD		EFFECTIVE DATE:	
4.____CHANGE/ADD/DELETE DEPENDENTS			

Check Appropriate Box	Full Name (first, middle, last)	Sex	Date of Birth (mm/dd/yyyy)	Age (last birthday)	Height (inch) & Weight (lbs)	Social Security Number
____CHANGE ____ADD ____DELETE						
____CHANGE ____ADD ____DELETE						
____CHANGE ____ADD ____DELETE						
____CHANGE ____ADD ____DELETE						

ANY OTHERHEALTH INSURANCE OR MEDICARE IN FORCE? ____YES (If YES, answer questions A through E) ____NO

A) INSURANCE COMPANY NAME_____ B) POLICY NUMBER_____

C) EMPLOYER THROUGH WHICH POLICY IS HELD (IF ANY)_____

D) INDIVIDUALS COVERED:_____

E) IF MEDICARE. IS IT ____MEDICARE A (HOSPITAL) ____MEDICARE B (HOSPITAL) ____OR BOTH A AND B

5.___BENEFICIARY CHANGE

Beneficiary	Relationship	Date of Birth
Beneficiary	Relationship	Date of Birth
Beneficiary	Relationship	Date of Birth

6.____CHANGES TO EMPLOYEE (ENTER ONLY THOSE ITEMS YOU WISH TO CHANGE.)

NAME		EFFECTIVE DATE
ADDRESS		
CITY	STATE	ZIP CODE
HOME PHONE	DATE OF BIRTH	
MARITAL STATUS	DATE OF MARRIAGE	DATE OF DIVORCE
CLASS CODE		EFFECTIVE DATE

On behalf of myself and any dependents listed above, I hereby apply for coverage under the Group Agreement issued to my employer. I understand that the benefits for which (we) will be eligible are in accordance with those described in. the Group Agreement and any changes provided for therein.I authorize my employer to deduct the necessary subscription rates, if any, from my wages or salary, with the understanding that he acts as my agent in all dealings with the plan, and that all acts performed by him and all notices given to him in such dealings are binding upon me, if not prohibited by statute or regulation.

EMPLOYER SIGNATURE_____ DATE_____
APPROVED BY (GROUP ADMIN)_____ DATE_____
EMPLOYEE SIGNATURE _____ DATE_____

Employee Name:_____ Date :_____

Height:_____(in ft.)
Weight:_____(in lbs.)

Health Statement

	Employee		Spouse		Child(ren)	
	Yes	No	Yes	No	Yes	No
1. Have you or any dependent been advised, diagnosed or treated for any of the following conditions? (Circle conditions to which "yes" answer applies)						
a. Disorders of the eye, ear, nose, or throat?	☐	☐	☐	☐	☐	☐
b. Hepatitis, intestinal bleeding, ulcer or any disease or disorder of the stomach, liver or kidney?	☐	☐	☐	☐	☐	☐
c. Lungs or respiratory disorders including bronchitis, 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), AIDS related complex (ARC), or (HIV)?	☐	☐	☐	☐	☐	☐
m. Sexually transmitted diseases (S.T.D.)	☐	☐	☐	☐	☐	☐
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?	☐	☐	☐	☐	☐	☐
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 experienced complications during pregnancy?	☐	☐	☐	☐	☐	☐
4. Are you taking any medication regularly?	☐	☐	☐	☐	☐	☐
5. 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.

Q#	Individual Name	Type of condition, treatment	Type of medication & dosage	Date Diagnosed	Current Status	Physician's Name / Clinic & Address

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