TakeCare
A Tan Holdings Company
P.O. Box 6578 Tamuning, Guam 96931

JUDICIARY OF GUAM
Enrollment Form/Change Request Form

1 Type of Request ▸ ❍ Initial Enrollment ❍ Change Request ❍ Add ❍ Cancel ❍ Delete ❍ Class/Coverage ❍ Update

2 Division ▾

3 Date Employed ▾ / /

4 Medical Coverage ▾
❍ PPO 1000 ❍ HSA 2000

5 Dental Coverage ▾
❍ DENTAL 1000

6 Medical and Dental Class ▾
❍ Class I: Employee Only
❍ Class II: Employee + Spouse/Cohabiting Partner
❍ Class III: Employee + Child/Children
❍ Class IV: Employee + Spouse/Cohabiting Partner + Child/Children

7 Employee Name ▾ LAST NAME FIRST NAME M.I.

8 Date of Birth ▾ / /

9 Gender ▾ ❍ M ❍ F

10 Social Security No. ▾

11 Employee Title ▾ Employee ID No. ▾

12 Marital Status ▾

13 Mailing Address ▾ VILLAGE STATE ZIP CODE

14 Home Telephone No. ▾ **15** Work Telephone No. ▾ **16** Mobile Phone No. ▾ **17** Email Address ▾

18 Please list enrollees below starting with yourself, your spouse/common law (if any), and then any children to be covered by the Health Plan. Official supporting documentation will be required to enroll Eligible Dependents, including your spouse/common law and children, for the purpose of verifying eligibility. Specifiy the relationship of each dependent to you (for example: husband, wife, common law, son, daughter, etc.). Please note that certain dependent relationships may not be recognized by your Group or the Health Plan. **PLEASE PRINT CLEARLY.**

NAME: Last	First	M.I.	RELATION TO YOU* (spouse, son, daughter, etc.)	IS DEPENDENT RESIDING OFF ISLAND? Yes/No	Add/ Delete	Gender	SSN	DOB	FOR TAKECARE USE
			SELF					/ /	
								/ /	
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To help us coordinate your care, please answer the following questions.

19 Does anyone, listed above, have other health insurance in addition to TakeCare? YES NO If YES, please fill out below.
Member Name(s):________ Other Health insurance:________
Name of Policy Holder:________ Policy No.:________ Effective Date:________

20 Does anyone, listed above, have MEDICARE coverage? YES NO If YES, please fill in section below.
(1) Member Name:________ MEDICARE No.:________
PART A - Effective Date:________ PART B - Effective Date:________ PART D - Effective Date:________
(2) Member Name:________ MEDICARE No.:________
❍ PART A - Effective Date:________ ❍ PART B - Effective Date:________ ❍ PART D - Effective Date:________

21 Please provide information if you have any ongoing care (optional):
____

***GOVERNMENT MEDICAL/DENTAL LOCK-IN PROVISION:** Medical/Dental Coverage cancellation will only be allowed during open enrollment

22 MISCELLANEOUS CHANGES ▾

(Subscribers who add or delete dependent(s) must meet a HIPAA Qualifying Event. CLASS CHANGES MUST BE DIRECTLY REPORTED TO YOUR PERSONNEL DEPARTMENT)

❍ **Medical** ❍ **Dental** Change from:________ to ________ Effective:________

(PLEASE ATTACH OFFICIAL DOCUMENTATION, i.e. MARRIAGE/BIRTH CERTIFICATE, COURT ORDER TO SUPPORT NAME CHANGE)

❍ Subscriber ❍ Dependent Name Change from:________ to ________

❍ Other (Specify):________ from ________ to ________ Effective:________

23 CANCELLATION OF COVERAGE (For Subscribers Only): ▾

❍ Medical Coverage Effective:________ ❍ Dental Coverage Effective:________
*Subscriber's medical/dental coverage cancellation will only be allowed during open enrollment or when you resign/terminate your employment.

REASON FOR CANCELLATION
❍ Termination / Resignation from employment

You accept the health insurance coverage provide through this employer by signing on the space provided below. By signing below, you have read the subscriber agreement section and temporary ID form and deductible plan insturctions on the back of this enrollment form.

24 Employee Signature ________ Date________

25 **GROUP VALIDATION AND EFFECTIVE DATE REQUIRED:**
Employer Group Representative Signature ________ Date________
▶ Effective Date ▸ / / Pay Period Effective (PPE) Date ▸ / /

For TakeCare Use Only

GROUP ID ▸ SG ID ▸ CLASS ▸ SCREEN ▸

MED ID ▸ DEN ID ▸ ENTER ▸ CARDS ▸ VERIFY ▸ SUB ID ▸