Government of Guam Enrollment/Change of Status Form

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

GovGuam Agency/Department	Date of Employment	Effective Date

Employee/Retiree Information

Last Name	First Name	M.I.

Social Security Number	Date of Birth	Sex	Martial Status

Mailing Address

Home Phone	Work Phone (Include EXT)	Cell Phone	Email Address

☐ **New Enrollment** – I am a new member (please indicate your medical & dental enrollment option)

☐ **Terminate Coverage** – Applicable only during Open Enrollment or upon employment termination

☐ **Change of Status** – Please indicate the type of change and make the necessary selections or updates in the required sections

- ☐ **Add Dependent -** List dependent to be added and attach any supporting documents.
- ☐ **Delete Dependent -** List dependent(s) below to be deleted.
- ☐ **Coverage Change -** Indicate your new medical or dental election (only during Open Enrollment).
- ☐ **Class Change -** Indicate your new Class Option and attach any supporting documents.
- ☐ **Update Information -** Indicate new information such as address or telephone changes.
- ☐ **Name Change -** Indicate your new name and attach supporting documents.

Election Option 1

☐ **PPO 1500 -** Individual $1,500 deductible / Family $3,000 deductible

☐ **HSA 2000** - Individual $2,000 deductible / Family $4,000 deductible

Deduction Class

☐ **Class I** – Employee / Retiree or Survivor Only

☐ **Class II** – Employee / Retiree or Survivor with Spouse

☐ **Class III** – Employee / Retiree or Survivor with Child/ren

☐ **Class IV** - Employee / Retiree or Survivor with Spouse and Child/ren

Election Option 2 - Must be enrolled in Medicare A & B

☐ **Retiree Supplemental Plan** - Retiree or Survivor

Deduction Class

☐ **Class I** – Employee / Retiree or Survivor Only

☐ **Class II** – Employee / Retiree or Survivor with Spouse

☐ **Class III** – Employee / Retiree or Survivor with Child/ren

For RSP Class III Enrollees, Choose Plan for Dependents:

☐ **PPO 1500** ☐ **HSA 2000**

Dental Election Options ☐ **Yes** I want dental coverage ☐ **No** I do not want dental coverage

Dependent Information (Spouse and dependent children up to 26 years of age)

Last Name	First Name	M.I.	Social Security No.	Sex	Birthdate	Relationship

Other Insurance – I have or my dependents have or will have health coverage with another carrier

Name of the Insured	Insurance Carrier	Effective Date

If Medicare

	Medicare Number	Effective Date
☐ Part A ☐ Part B ☐ Part D		

I agree that I shall abide by the provisions of cover age 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 change in eligibility to include my dependents. I understand that newly eligible dependents, to include legal guardians, may only be added within 30 days from becoming eligible or during Open Enrollment period. I understand that Aetna International 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 Aetna International. Should this occur, I understand and agree I maybe responsible for the cost of all healthcare provided to me and my dependents. I understand that the providing of coverage and service does not constitute acceptance of eligibility by Aetna International until eligibility for coverage has been proven. I further understand that any claims asserted by myself or my dependents against Aetna International or any provider, whether based in tort, contractor 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 a false or deceptive statement is guilty of insurance fraud.

Employee Signature: ______________________ Date: ______________________

Distribution:
White=Aetna International
Yellow=Personnel
Pink=Payroll
Gold=Member

 For Aetna use only CSA: ____________ For GovGuam use Effective Date: ____________