GOVGUAM
Self Insured Dental Program Enrollment/Change of Status Form

Administered by: TakeCare
A TanHoldings Company
P.O. Box 6578 Tamuning, Guam 96931

1 Type of Request ▼

- ❍ **Initial Enrollment**
- ❍ **Terminate Coverage**
- ❍ **Change of Status:** Please indicate the type of change and make the necessary selections or updates in the required sections.
- ❑ **Update Personal Information, Change to:**_____

❑ Add Dependent ❑ Delete Dependent
❑ Plan Change ❑ Class Change
❑ Update information ❑ Name Change

2 Agency/Department ▼

3 Date Employed ▼ / /

4 Employee Status ▼

❍ **Employee**
❍ **Retiree**
❍ **Survivor**

If retiree or survivor, are you under:
❍ **DB** or ❍ **DC**

5 Choose a coverage class: ▼

- ❍ **Class I:** Subscriber Only
- ❍ **Class II:** Subscriber + Spouse/Domestic Partner
- ❍ **Class III:** Subscriber + Child/ren
- ❍ **Class IV:** Subscriber + Spouse/Domestic Partner & Child/ren

6 Employee Name ▼ LAST NAME FIRST NAME M.I.

7 Date of Birth ▼ / /

8 Gender ▼ ❍ **Male** ❍ **Female** ❍ **X** (Unspecified or another gender identity)

9 Social Security No. ▼

10 Employee Title ▼

11 Mailing Address ▼ VILLAGE STATE ZIP CODE

12 Home Telephone No. ▼

13 Work Telephone No. ▼

14 Mobile Phone No. ▼

15 Email Address ▼

16 Please list enrollees below starting with yourself, your spouse/domestic partner (if any), and then any children to be covered by the Dental Plan. Official supporting documentation will be required to enroll Eligible Dependents, including your spouse/domestic partner and children, for the purpose of verifying eligibility. Specifiy the relationship of each dependent to you (for example: husband, wife, domestic partner, 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 (Male, Female or X=Unspecified or another gender identity.)	SSN	DOB
			SELF						/ /
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To help us coordinate your care, please answer the following questions. Any omission of information or intentional misrepresentation in answering the following questions of you and your dependents may result in denial of benefits and the termination of your coverage.

17 Does anyone, listed above, have other dental insurance in addition to TakeCare? ❍ YES ❍ NO If YES, please fill out below.

Member Name(s):_____ **Other Dental insurance** _____

Name of Policy Holder:_____ **Policy No.:** _____ **Effective Date:**_____

***Government Dental Lock-In Provision: Dental cancellation will only be allowed during open enrollment.**

18 MISCELLANEOUS CHANGES ▼ (CLASS CHANGES MUST BE DIRECTLY REPORTED TO YOUR PERSONNEL DEPARTMENT)

❑ **Dental** Change from: _____ to _____ Effective:_____

❍ **Add** ❍ **Delete** dependent(s) (in item #17) from: _____to_____Effective:_____

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

❍ Subscriber ❍ Dependent Name Change from:_____ to _____

❍ Agency/Department from: _____ to _____ Effective:_____

❍ Other (Specify): _____from _____ to_____ Effective:_____

19 CANCELLATION OF COVERAGE (For Subscribers Only): ▼

❑ Dental Coverage Effective: _____

*Subscriber's 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 dental insurance coverage provided 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 instructions on the back of this enrollment form.

20 Employee Signature _____ Date_____

21 GROUP VALIDATION AND EFFECTIVE DATE REQUIRED:
Employer Group Representative Signature _____ Date_____

❍ Applicable supporting documents attached

▶ **Dental** Effective Date___ /___ /___

▶ Pay Period Ending Date___ /___ /___

For TakeCare Use Only

GROUP ID ▸ SG ID ▸ CLASS ▸ MED ID ▸ DEN ID ▸

SCREEN ▸ ENTER ▸ VERIFY ▸ SUB ID ▸

PLEASE READ CAREFULLY AND ACKNOWLEDGE BELOW

THIS IS YOUR TEMPORARY ID FORM This form will serve as a temporary identification. It is valid for thirty one (31) days from the effective date of coverage. However, in order to be valid, the form must be signed by you and your Group HR/Personnel Representative, as well as, be approved and accepted by TakeCare. Please keep it with you and present it each time you require services. You will be personally responsible for the cost of services if you are not eligible or the services are not covered. If you do not receive your dependent's membership card within thirty one (31) days after you become eligible, please call our **Customer Service** number at **(671) 647.3526.**

SUBSCRIBER AGREEMENT SECTION "I hereby authorize my employer to deduct from my earnings any employee contribution required to cover my share of the premium for group benefits for which I am eligible. If I am on Leave Without Pay (LWOP), then I hereby agree that I am responsible for my premium payments for group benefits for which I am eligible. I agree that I shall abide by the provisions of coverage in the Government of Guam Self Insured Dental Program, administered by TakeCare. 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 thirty one (31) days from becoming eligible or during the open enrollment period of my group. I have read and understand the eligibility requirements and attest that all my dependents and I meet these requirements. I agree to provide TakeCare all documents necessary to support eligibility. I understand that TakeCare has the right to request required documents at anytime after enrollment. I understand that failure to submit required documents would result in a loss of coverage or services at the discretion of TakeCare. Should this occur, I understand and agree that I will be responsible for the cost of all healthcare services provided to me and/or my dependents. I understand that providing coverage and services do not constitute acceptance of my eligibility by TakeCare until I provide all documents requested by TakeCare to provide my dependents' and my eligibility for coverage. I also give my consent to TakeCare or its designee to access and use my dental records or the dental records of my dependents to assure correct and timely medical diagnosis and for purposes, as required by law, of Utilization Review, Quality Assurance, surveys and processing of claims. I understand that any claims asserted by my dependents or me against Government of Guam Self Insured Dental Program, its employees or agents, whether based in contract, tort or otherwise for professional liability, are subject to the dispute resolution procedures set forth in the Group Health Insurance Certificate. Adverse benefit determinations, including rescissions of coverage, are subject to the PPACA Claims Procedures. I have received a copy of the Group Health Insurance Certificate that contains the benefits, limitations and exclusions applicable to my healthcare plan. I understand that any material omission or intentional misrepresentation in answering the questions on this form may result in the denial of benefits and termination of my dependent(s) or my coverage. I agree and understand that TakeCare will charge an additional service, collection, or attorneys fee for the collection of any amounts owed to TakeCare or the processing of a returned check for services rendered or products purchased on behalf of members covered by this plan."

Employee's Initials _____ Date_____