Enrollment Application / Change of Status Form

Company or Group Name	Job Title	Date of Employment

First Name, M.I., Last Name	Social Security No.

Mailing Address

Home Phone	Work Phone & Ext.	Cell Phone / Other Phone	Date of Birth	Sex	Marital Status

E-mail Address

◯ **TERMINATE ALL COVERAGE** - Check ✓ this item if you are currently enrolled and You Wish to Terminate your Coverage.

Reason for Termination

◯ **Termination of Employment**

◯ **Enrolling Under Spouse's Plan**

◯ **You are Electing Coverage under COBRA** please ask your employer for details

◯ **Other:**

◯ **CHANGE OF STATUS** - Make appropriate checks ✓ to the items below.

◯ **Add Dependents**

◯ **Delete Dependents**

Please complete the Dependent Information section below on the dependent(s) you wish to Add or Delete

◯ **Update your Personal Information such as address or phone nos. to the information completed above**

◯ **NEW ENROLLEE** - Check ✓ this item if you are either (1) A **NEW ENROLLEE**, or (2) You wish to make changes to your existing SelectCare Plan during your group's **Open Enrollment** Period.
Please complete ALL the information below! The information and coverage choices which you provide below will supersede all prior information and coverage choices we have previously received from you.

Health Plan Choice

Dental Plan Option* ◯ **YES,** I want Dental Coverage ◯ **NO,** I do not want Dental Coverage

Vision Plan Option* ◯ **YES,** I want Vision Coverage ◯ **NO,** I do not want Vision Coverage

* Not all groups offer Dental &/or Vision Plans; these Options have to be offered to you under your Group benefits. Cancellation of your Dental Plan is ONLY allowed during an Open Enrollment Period. The cancellation of your Dental Plan will also result in the cancellation of your Medical Plan.

Accidental Death Benefit Most plans include a $5,000 Accidental Death Benefit for each Subscriber. Please check with your employer if applicable.

Beneficiary Name	Date of Birth	Relation to Subscriber

Other Insurance Will you or any of your covered dependents have **other health coverage** during your group's plan/contract year? If "Yes", please **indicate the effective date(s)** of such coverage below.

Person with Dual Health Insurance Coverage	Medicare Part A	Medicare Part B	Medicare Part D	Medicaid	Other Insurance Carrier Eff. Date	Name of Carrier

Dependent Information Spouse & dependent children up to 26 years of age.
Children between 19 to 26 must submit evidence of being a full-time student to be eligible for **Off-Island** coverage.

First Name & M.I.	Last Name	Relation to Subscriber	Social Security No.	Sex	Date of Birth

On behalf of myself and my dependents, I agree to or with the following:
I acknowledge that by enrolling in a health plan, coverage is provided by one of the following entities (referred to as "Carrier"): Tokio Marine Pacific Insurance, Ltd; Tokio Marine & Nichido Fire Insurance Co.; Global Pacific Insurance Co.
The policy contract under which I am enrolled will determine the rights and responsibilities of member(s) and will govern in the event they conflict with any Schedule of Benefits, Member Handbook, summary or other description of the plan. I agree that I shall abide by the provisions of coverage contained in the policy.
I have read and understand the eligibility requirements and attest that I and all my dependents meet these requirements. 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 30 days from becoming eligible or during an Open Enrollment period for my group.
I understand and agree that there is no coverage unless my Enrollment Application/Change of Status Form has been accepted and approved by Calvo's SelectCare. Even if this enrollment form is approved, any material misstatements or omissions may result in past or future claims being contested and the policy or my coverage under the policy being contested. I understand that Calvo's SelectCare has the right to request required documents to verify eligibility at any time and failure to submit these documents may result in a loss of coverage or service at the discretion of Calvo's SelectCare. Should a loss of coverage occur, I understand and agree that I may be responsible for the cost of all health care provided to me and my dependents. I understand that the providing of coverage and service does not constitute acceptance of eligibility by Calvo's SelectCare until eligibility for coverage has been proven.
I (and my dependents) hereby authorize any Medical/Health Care Provider or Facility that has any records or knowledge of me (us) or my (our) health to give Calvo's SelectCare any such information. A copy of this authorization shall be as valid as the original. I understand that any claims asserted by myself or my dependents against the Carrier or any health provider, whether based on tort, contract, or otherwise (including professional liability) are subject to Binding Arbitration. I have read the benefit brochure and my questions pertaining to the Calvo's SelectCare Plan have been answered satisfactorily and will be further explained upon my request by a Calvo's SelectCare representative or my personnel office. I hereby authorize my employer to deduct any required cost for this program.

Signature of Employee **Date Signed** **Authorized Group H.R./Payroll Signature**

Distribution: White=SelectCare Yellow=Personnel Pink=Payroll Gold=Member