Government Group Health Insurance
P.O. Box 5234 CHRB Saipan, MP 96950
Tel. (670) 664-1100 / Fax (670) 664-1115
AETNA Global Benefits 1(800) 231-7729
WEBSITE: www.aetna.com

FOR GHI USE ONLY:	
MAGIC/Entered:	
PAYROLL/PPB:	
AGB/Eff. Date:	

Enrollment / Waiver / Change Request

Employee/Retiree/Surviving Spouse Completes Sections A-E

A. EMPLOYEE / RETIREE / SURVIVING SPOUSE INFORMATION

Last Name, First Name, Middle Initial	Social Security Number	Date of Birth (M/D/YEAR)	Gender (**M/F**)

Home Address or Post Office Box	Home Phone Number	E-mail Address

City	State	Zip Code	Department Name	Division Name	Work Phone Number

B. TYPE OF ACTIVITY

☐ ***WAIVER:*** **I fully understand and acknowledge** that by affixing my signature below, **I am waiving medical coverage** under the GGHI Program, and that the CNMI government shall have no liability to cover any medical expenses and/or claims submitted by me or my dependents.

ENROLLMENT - NEW SUBSCRIBER:

☒ Active Employee ☐ Retiree – *must be enrolled prior to retirement* ☐ Surviving Spouse

Date of Hire:_____ **Date of Retirement:**_____ **Date Benefits Began:** _____

CHANGE:

☐ Add Spouse
☐ Add Dependent Child
☐ Add Domestic Partner
☐ Name Change
☐ Change of Dept. or Division
☐ Other : _____

REMOVE:

☐ Spouse
☐ Domestic Partner
☐ Dependent Child

HIGH OPTION :

☐ **I fully understand and acknowledge** that by affixing my signature below, **I am choosing the PPO High Option coverage** under the GGHI Program. My initials below signify my consent to pay the premium.

TERMINATE COVERAGE:

☐ **I fully understand and acknowledge** that by affixing my signature below, **I am terminating medical/health insurance coverage** under the GGHI Program and, if I am a retiree, may not be eligible to re-enroll at a later date.

C. PLAN OPTIONS / SUBSCRIBERS PREMIUMS

PLAN DESCRIPTION (ENROLLMENT CODE)		**Retiree: Semi-Monthly**		**Active Employee: Bi-Weekly**	
		☐ ***HIGH OPTION***	☐ ***LOW OPTION***	☐ ***HIGH OPTION***	☐ ***LOW OPTION***
SINGLE	**(1)**	_____$141.10	☐ $83.48	_____$128.27	☐ $75.89
COUPLE (Member + 1)	**(2)**	_____$289.25	☐ $171.13	_____$262.96	☐ $155.57
FAMILY (Member + 2 or more)	**(3)**	_____$451.52	☐ $267.11	_____$410.47	☐ $242.83

D. INDIVIDUALS COVERED – List Individuals for whom you are adding/changing/removing coverage

(A) Add (C) Change (R) Remove	Name (First, MI, Last)	Relationship	Gender M or F	Date of Birth (M/D/YEAR)	Social Security Number

E. LIST OTHER HEALTH INSURANCE UNDER WHICH YOU/SPOUSE/DEPENDENTS WILL BE COVERED WHILE A MEMBER OF GOVERNMENT GROUP HEALTH INSURANCE - include Medicaid, Medicare, Other Insurance.				
Policy Holder	**Member Covered**	**Name of Other Insurance**	**Address**	**Effective Date**

IMPORTANT INFORMATION BELOW – PLEASE READ CAREFULLY BEFORE SIGNING

1) **All new enrollees** are required to submit the following (as applicable):
   - ☐ Marriage Certificate
   - ☐ Affidavit of Domestic Partner form (with attachments)
   - ☐ Birth Certificate(s) of dependent child(ren)
   - ☐ Court documents attesting to an adoption decree or appointment of legal guardianship

2) **Authorization for automatic payroll or retirement pension deduction:** The CNMI Government and/or the NMI Retirement Fund is hereby authorized to make the required deduction from my bi-weekly salary, or if a retiree, my semi-monthly retirement pension to pay my portion of the premium. This authorization includes **two additional** premium payments that must be made in my final paycheck to provide for thirty (30) days of Government Health Insurance (GHI) coverage after my termination from the CNMI Government employment.

   Additionally, I acknowledge that if I do not contribute for three (3) consecutive pay periods, coverage will be terminated automatically.

3) **Certification, Acknowledgement and Authorization to release medical information:** I certify that the statements provided in this application are true and complete to the best of my knowledge and hereby authorize GHI to verify information or statements provided by me in connection with this application. I understand that coverage is in effect on the date shown herein above. I hereby authorize any licensed physician, medical practitioner, or institution that has any records or knowledge of my or my dependents' health to give to GHI and/or its carrier, insurance company or re-insurer any such information for the purpose of applying and maintaining coverage. A photocopy of this authorization shall be valid as the original. This authorization is effective when I sign below and shall remain in effect as long as the carrier processes claims on my behalf.

Applicant's Signature:	**Date:**
APPLICATION DISPOSITION ☐ **APPROVED** ☐ **DISAPPROVED** **COMMENT:** _____	
Plan Administrator's Name / Signature:	**Date:**

Original – GHI **COPY 1 – ENROLLEE** **COPY 2 – PAYROLL**