



# Group Health & Life Insurance Trust Fund

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<b>FOR GHLI USE ONLY:</b>	
MAGIC/Entered:	_____
Payroll/PPE:	_____
AGB/Eff. Date:	_____

## 2018 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 (MM/DD/YY)		Gender (M/F)
Street or PO Box Address			Home Phone Number		E-mail Address		
City	State	Zip	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 GHLI Program, and that the CNMI government shall have no liability to cover any medical expenses and/or claims submitted by me or my dependents. **(STOP HERE, continue to signature page)**

**ENROLLMENT—NEW SUBSCRIBER:**

Active Employee \_\_\_\_\_ Retirement—must be enrolled prior to retirement \_\_\_\_\_ Surviving Spouse \_\_\_\_\_  
 Date of Hire: \_\_\_\_\_ Date of Retirement: \_\_\_\_\_ Date Benefits Began: \_\_\_\_\_

<b>CHANGE:</b>		<b>REMOVE:</b>
<input type="checkbox"/> Add Spouse	<input type="checkbox"/> Name Change	<input type="checkbox"/> Spouse
<input type="checkbox"/> Add Dependent Child	<input type="checkbox"/> Change of Dept. or Division	<input type="checkbox"/> Domestic Partner
<input type="checkbox"/> Add Domestic Partner	<input type="checkbox"/> Other: _____	<input type="checkbox"/> 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 GHLI 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 GHLI 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	LOW	BASIC	HIGH	LOW	BASIC
Employee	<input type="checkbox"/> \$86.30	<input type="checkbox"/> \$27.56	<input type="checkbox"/> \$2.38	<input type="checkbox"/> \$79.66	<input type="checkbox"/> \$25.44	<input type="checkbox"/> \$2.20
Employee + Spouse or One Dependent	<input type="checkbox"/> \$176.91	<input type="checkbox"/> \$56.49	<input type="checkbox"/> \$4.88	<input type="checkbox"/> \$163.30	<input type="checkbox"/> \$52.15	<input type="checkbox"/> \$4.50
Employee + Family	<input type="checkbox"/> \$276.15	<input type="checkbox"/> \$88.18	<input type="checkbox"/> \$7.60	<input type="checkbox"/> \$254.91	<input type="checkbox"/> \$81.40	<input type="checkbox"/> \$7.01

### D. INDIVIDUALS COVERED - List individuals for whom you are adding/changing/removing coverage

	Name First, MI, Last	Relationship	Gender	Date of Birth	SS#
(A) ADD					
(C) CHANGE					
(R) REMOVE					

**E. LIST OTHER HEALTH INSURANCE UNDER WHICH YOU/SPOUSE/DEPENDENTS WILL BE COVERED WHILE A MEMBER OF GOVERNMENT GROUP HEALTH INSURANCE - Include Medicaid, Medicare, and 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 Partnership 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, the NMI Retirement Fund and/or NMI Settlement 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 personal paycheck to provide for thirty (30) days of Group Health & Life Insurance Trust Fund (GHLI) 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 GHLI 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 GHLI and/or its carrier, insurance company or reinsurer 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:
<b>APPLICATION DISPOSITION</b>	
<input type="checkbox"/> APPROVED	<input type="checkbox"/> DISAPPROVED <input type="checkbox"/> COMMENTS: _____
Plan Administrator's Name/Signature:	Date: