Appendix BB.

FSM MiCare Plan

P.O. Box 2156
Kolonia, Pohnpei FM 96941
Email Address: info@micareplan.fm

ENROLLMENT APPLICATION

INSTRUCTIONS: Use ink or typewriter to complete form. All questions must be answered.

IMPORTANT: Any misrepresentation and/or concealment of material information that the applicant herein may make shall render his contract void from the beginning.

FAMILY NAME	FIRST NAME	MI	AGE	BIRTHDATE

SEX _____ MALE _____ FEMALE | CIVIL STATUS: _____SINGLE _____WIDOWER _____MARRIED _____SEPARATED | HEIGHT _____FT _____IN | WEIGHT_____

ADDRESS: HOME: _____ TEL. NO. _____

_____

BUSINESS: _____TEL. NO. _____FAX NO. _____

DEPT/OFFICE: CITIZENSHIP: OTHERS: / /

Specify:

SOCIAL SECURITY NO: RESIDENCY:

OPTIONS: / / BASIC ()BW / / SUPPLEMENTAL RESIDENT () BW / / SUPPLEMENTAL-NONRESIDENT () BW / / NON REFFERAL (NR) () BW

FAMILY MEMBERS To be filled out by the Head of Family or Provider	RESIDENCY	OPTIONS	SEX	RELATIONSHIP	BIRTHDATE

AGREEMENT: I agree that I (and my dependents) shall abide by the provisions of the MiCARE Plan Schedule of benefits as contained in applicable laws, rules and regulations, and informational material. I understand that it is my responsibility to report any changes in the eligibility of my dependents. I (and my dependents) authorize any health care provider or facility that has any records or knowledge of my (us) or my (our) health to provide any such information to the administration. I have read the MiCARE Plan brochure and my questions have been answered satisfactorily.

Signature of Enrollee:_____ Date:_____

PAYROLL DEDUCTION AUTHORIZATION: I authorize my employer to deduct my contribution to the MiCARE Plan from my compensation each payroll period. My authorization also includes any increases, decreases, adjustments, assessments or cancellations to the contributions as required by the MiCARE Plan under applicable laws, rules, and regulations, or other informational material.

Signature of Enrollee: _____ Date: _____

FOR OFFICIAL USE ONLY

EFFECTIVE DATE	TOTAL PREMIUM CONTRIBUTION	PARTICIPATING AGENCY DEPT. NO. _____ HIRE DATE: _____