MiCARE Health Insurance Plan

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

Amendment of Enrollment

I ______________________________________ with Insurance ID# _____________________
employed at ____ would like to request your office to make the following amendments to my enrollment including my dependents in the MiCare Health Insurance Plan. My contact information is as follows:

Current Address	
Phone Numbers	(h) (c)
Email Address:	

A. CHANGES OF OPTION

Name of Member	Amended From	To	Residency

B. ADDITIONAL DEPENDENT(s)

Name of Member	Option	Sex	Relationship	Birthdate	Residency

C. DELETION OF DEPENDENT(s)

Name of Member	Reason for Deletion

I hereby authorize the Plan to correct or complete the request for amendment and agree that (and my dependents) shall abide by the provision of MiCare Plan's schedule of benefits as contained in applicable law, rules and regulations and informational materials.

I hereby authorize also my employer to deduct my contributions for the increase, decreases and adjustments to MiCare Plan from any compensation each pay period. __________________________

____
Signature of Enrollee Date

FOR OFFICIAL USE ONLY

EFFECTIVE DATE	TOTAL PREMIUM CONTRIBUTION	INCREASE BY ________ DECREASE BY________