

## CNMI Department of Finance Group Health& Life Insurance Trust Fund P.O. Box 5234 CHRB Saipan, MP 96950

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FOR GHLI USE ONLY:

Agency Code: Payroll/PPE:

AGB/Eff. Date:

2025 ENROLLMENT / WAIVER / CHANGE REQUEST

Employee / Retiree/ Surviving Spouse Completes Sections A-E

	EMPLO	YEE / RETI	REE / SI	URIVIVI	NG SPO	USE INFORM	MATION		
	Last Name, First Name, Middle Initial				ial Security	v Number	Date of Bi	rth (MM/DD/YY)	Gender (M/F)
Mailing Address			Contact Number			E-mail Address			
City	State Zip Departme			nt Name Division Name Work Phone Number			nber		
		B.	TYPE	OFACTI	VITY				
Progra	<b>R:</b> I fully understand and ackno m, and that the CNMI governm dependents. <b>(STOP HERE, co</b>	nent shall hav	e no liabil	ity to cov	er any me		-	-	
ENROLLMENT-	NEW SUBSCRIBER:								
Active EmployeeRetirement—must be enrolled prior to retirementSurviving SpouseDate of Hire:Date of Retirement:Date Benefits Began:									
CHANGE:							REMO	VE:	
🗖 Add S	pouse	🗖 Nam	e Change				Spouse		
🗖 Add D	Add Dependent Child Change of Dept. or Division Domestic Partner								
🗖 Add D	omestic Partner	Other	r:					Dependent Ch	ild
	I, fully understand and acknown of the second se					am choosing the	e PPO High	Option coverage u	nder the GHLI
TERMINATE COVERAGE: I, fully understand and acknowledge that by affixing my signature below, I am terminating medical/health insurance coverage under the GHLI Program.   Retirees: I, acknowledge that by terminating my insurance I will not be eligible to enroll in the future.									
	С.	PLAN OPT	'IONS / S	UBSCRI	BERS PF	REMIUMS			
PLAN DESCRIPTION (ENROLLMENT CODE) Retiree:				Semi-Monthly		Active employee: Bi-Weekly			
		HIGH	LO	W	BASI	C HI	GH	LOW	BASIC
Employee		\$121.23	3 🗖 \$6	55.34	<b>□</b> \$37.8	81 <b>D</b> \$1	11.90	\$60.32	<b>D</b> \$34.90
Employee + Spouse or One Dependent				133.95	<b>D</b> \$77.		29.39	\$123.64	<b>\$</b> 71.56
Employee + Fam	ily	\$387.93	<b>D</b> \$2	209.08	<b>1</b> \$121	.01 🛛 \$3	58.09	\$193.00	\$111.70
D. I	NDIVIDUALS COVERED -	List individ	luals for	whom	you are	adding/cha	anging/	removing cov	erage
( A ) ADD	Name First, MI, Last					Relationship	Gender	Date of Birth	SS#
( C ) CHANGE									
( R ) REMOVE									

E. Medicare Information								
Medicare ID Number	Last Name	First Name	Gender					

## **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
  - Driver's License / Passport / Municipality ID / Military ID

2) Authorization for automatic payroll or retirement pension deduction: The CNMI Government, the NMI Retirement Fund, NMI Settlement Fund or any Autonomous Agency participating in the GHLI program 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.

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

3) **Certification, Acknowledgment 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 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:					
Pacifica Insurance:			Date:					
APPLICATION DISPOSITION								
	DISAPPROVED	СОМММ	ENTS:					
Plan Administrator's Name/Signature:			Date:					