



CNMI Department of Finance  
 Group Health & Life Insurance Trust Fund  
 P.O. Box 5234 CHRB Saipan, MP 96950  
 Tel. (670) 664-1100 / Fax (670) 664-1115



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

**2024 ENROLLMENT / WAIVER / CHANGE REQUEST**  
*Employee / Retiree/ Surviving Spouse Completes Sections A-E*

**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: \_\_\_\_\_

**CHANGE:**

- |   |  |
|---|--|
| <input type="checkbox"/> Add Spouse           | <input type="checkbox"/> Name Change                 |
| <input type="checkbox"/> Add Dependent Child  | <input type="checkbox"/> Change of Dept. or Division |
| <input type="checkbox"/> Add Domestic Partner | <input type="checkbox"/> 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 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. **Retirees: I, acknowledge that by terminating my insurance I understand that I will not be eligible to enroll in the future.**

**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"/> \$115.45	<input type="checkbox"/> \$62.23	<input type="checkbox"/> \$36.01	<input type="checkbox"/> \$106.57	<input type="checkbox"/> \$57.44	<input type="checkbox"/> \$33.24
Employee + Spouse or One Dependent	<input type="checkbox"/> \$236.67	<input type="checkbox"/> \$127.57	<input type="checkbox"/> \$73.83	<input type="checkbox"/> \$218.47	<input type="checkbox"/> \$117.76	<input type="checkbox"/> \$68.15
Employee + Family	<input type="checkbox"/> \$369.45	<input type="checkbox"/> \$199.13	<input type="checkbox"/> \$115.24	<input type="checkbox"/> \$341.03	<input type="checkbox"/> \$183.81	<input type="checkbox"/> \$106.38

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

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

<b>E. Medicare Information</b>			
<b>Medicare ID Number</b>	<b>Last Name</b>	<b>First Name</b>	<b>Gender</b>

**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.

**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:
Pacifica Insurance:	Date:
<b>APPLICATION DISPOSITION</b>	
<input type="checkbox"/> APPROVED	<input type="checkbox"/> DISAPPROVED
<input type="checkbox"/> COMMENTS: _____	
Plan Administrator's Name/Signature:	Date: