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

ENROLLMENT APPLICATION

☐ NEW ☐ REACTIVATION $100

LAST NAME	FIRST NAME	MI	AGE	BIRTHDATE

GENDER: ☐ MALE ☐ FEMALE **CIVIL STATUS**: ☐ SINGLE ☐ WIDOWER ☐ MARRIED ☐ SEPARATED

SSN#:_____ **CITIZENSHIP**: ☐ FSM ☐ USA ☐ OTHER_____

ADDRESS: MAILING: P.O BOX _____ STATE: _____ ZIP CODE:_____ TEL. NO. _____

EMAIL:_____

PHYSICAL ADDRESS: VILLAGE_____ MUNICIPALITY_____ STATE_____

PLAN TYPE ☐ INDIVIDAL PLAN ☐ GROUP/EMPLOYER PLAN

EMPLOYER/GROUP NAME: _____PHYSICAL ADRESS_____TEL. NO. _____

PLAN OPTIONS: ☐ *BASIC* ☐ *BASIC PLUS* ☐ *SUPPLEMENTAL* ☐ *SUPPLEMENTAL-PLUS* ☐ *RETICARE* ☐ *NON REFR*

	BASIC	*BASIC PLUS*	*SUPPLEMENTAL*	*SUPPLEMENTAL-PLUS*	*RETICARE*	*NON REFR*
BIWKLY PAY 100%:	$21.10	$36.07	$59.11	$115.22	$29.54	$11.10

DEPENDENTS: **1.** To be completed by the Enrollee/Employee/Individual **2.** Indicate if any dependent is Special Needs by filling in Yes or or No, If yes, additional verification is required **3.** Indicate which State each dependent is currently living in **4.** Indicate which Option each dependent will be utilize NR/BA/BAPlus/SR/SRPlus/RC

FIRST AND LAST NAME	*RELATIONSHIP*	*GENDER M or F*	*DATE OF BIRTH*	*PLAN OPTION*	*SPECIAL NEEDS*	*RESIDENCY*
1. Sample Sample	*Spouse*	*F*	*5/7/80*	*SRPlus*	*No*	*PNI*
2.						
3.						
4.						
5.						
6.						
7.						
8.						
9.						

PAYROLL DEDUCTION AUTHORIZATION: By initialing this statement, 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. _____

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. Any misrepresentation and/or concealment of material information provided herein shall render contract void and membership denied, and applicant may be subject to civil penalties.

Signature: _____ **Date:** _____

FOR OFFICIAL USE ONLY

EFFECTIVE DATE	TOTAL PREMIUM CONTRIBUTION	EMPLOYER/BUSINESS
		DEPT. NO. _____ HIRE DATE: _____

Revised 6/7/2024