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

MEMBERSHIP AMMENDMENT

LAST	FIRST	MI	INSURANCE ID NUMBER

Current Mailing Address			
Phone Numbers	Home:	Cell:	Work:
Email:			

Requesting with MiCare office to make the following amendments to my enrollment including my dependents in the MiCare Health Insurance Plan:

A. CHANGE PLAN OPTION

NAME OF DEPENDENT	CURRENT PLAN	NEW PLAN	RESIDENCY

B. ADD DEPENDENT(s)

*1. Indicate Yes or No if added Dependent is new to MiCare 2. Indicate Yes or No if added Dependent is Special Needs

FIRST NAME	LAST NAME	NEW	RELATIONSHIP	GENDER	DOB	PLAN OPTION	SPECIAL NEEDS	RESIDENCY

C. DELETION OF DEPENDENT(s)

First Name	Last Name	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 understand that no changes are allowed after the Enrollment Period except for qualifying Status Change
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_____