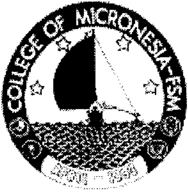


COLLEGE OF MICRONESIA – FSM

P.O. Box 159, Kolonia, Pohnpei
Federated States of Micronesia 96941

Tel: (691)320-2480/2481/2482 Fax: (691(320-2479 E-Mail: persofficer@comfsm.fm

Office of Human Resources

June 21, 2006

MEMORANDUM

TO: All Faculty and Staff

FROM: Rencelly Nelson, HR Director
THROUGH: President

SUBJECT: FSM MiCare Open Season

July is open season for the FSM MiCare Plan. Employees who are currently enrolled and wish to make changes in their plans or dependents may do so at this time. Likewise, employees who are not enrolled but wish to, provided that they are full-time employees may also enroll at this time.

Attached are the application and amendment forms for your use. Please submit your form to the HR Office by July 30, 2006. Changes will be effective October 1, 2006. Thank you and please let me know if you have any questions in regard to the above or need additional information.

Thank you.

FSM HEALTH INSURANCE

REQUEST FOR AMENDMENT OF ENROLLMENT

I ______________________________ with Insurance ID # ______________________________
employed at ____ would like
to request your office to make the following amendments to my enrollments including my dependents in the FSM Health Insurance Plan.

A. CHANGES OF OPTION

Name of Member	From	Amended To

B. ADDITIONAL DEPENDENT(s)

Name of Member	Options	Sex	Relationship	Birthdate

C. DELETION OF DEPENDENT(s)

Name of Member	Name of Member

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

I hereby authorize also my employer to deduct my contributions for the increase decrease and adjustments to the NGEHI Plan from my compensation each pay period.

______________________________ ______________________________
Signature of Enrollee Date

FOR OFFICIAL USE ONLY

Effective Date	Total Premium Contribution

Rev. (3/12/98

NATIONAL GOVERNMENT EMPLOYEES HEALTH INSURANCE PLAN

ENROLLMENT APPLICATION

INSTRUCTIONS: Use ink or typewriter to complete form. All questions must be answered.

IMPORTANT: Any misrepresentation and/or concealment of material information that the applicant herein may make shall render his contract void from the beginning.

FAMILY NAME	FIRST NAME	MI	AGE	BIRTHDATE

SEX ____ MALE ____ FEMALE | CIVIL STATUS ____ SINGLE ____ MARRIED ____ WIDOWER ____ SEPARATED | HEIGHT ____ FT ____ IN | WEIGHT ____

NO. STREET CITY TOWN

ADDRESS: HOME: ______________________ TEL. NO. ______________

BUSINESS: ______________________ FAX NO. ______________

DEPT/OFFICE: CITIZENSHIP: OTHERS: SPECIFY

SOCIAL SECURITY NO. NGEHI PLAN ID NO.

OPTIONS: / / BASIC (5.28)BW / / SUPPLEMENTAL RESIDENT (13.20) BW / / SUPPLEMENTAL-NONRESIDENT (18.48) BW

FAMILY MEMBERS To be filled out by the Head of Family or Provider	CONTRACT	OPTIONS	SEX	RELATIONSHIP	BIRTHDATE

AGREEMENT: I agree that I (and my dependents) shall abide by the provisions of the NGEHI 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. I have read the NGEHI PLAN brochure and my questions have been answered satisfactorily.

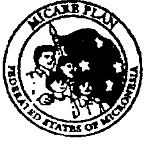
Signature of Enrollee: ______________________ Date: ______________

PAYROLL DEDUCTION AUTHORIZATION: I authorize my employer to deduct my contribution to the NGEHI 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 NGEHI Plan under applicable laws, rules, and regulations, or other informational material.

Signature of Enrollee: ______________________ Date: ______________

FOR OFFICIAL USE ONLY

EFFECTIVE DATE	TOTAL PREMIUM CONTRIBUTION	PARTICIPATING AGENCY DEPT. NO. __________ HIRE DATE: __________



MiCare

Federated States of Micronesia

P.O. Box 2156 Kolonia, Pohnpei FM 96941 Tel.: (691) 320-2549 or 320-5865 Fax: (691) 320-5693

June 13, 2006

MEMORANDUM

To : All Participating Governments, Agencies and Private Businesses

From : Administrator, MiCare

Subject : Open Season – MiCare (known as FSM Health Insurance Plan) (July 1-31, 2006)

This is to inform all concern that the regular Open Season for MiCare Plan is July 1-31, 2006. Any employee who is not enroll in the Plan at this time may enroll during this period. Enrollees may cancel or change from one Plan Option to another or add/delete dependents. Those employees who do not wish to make any changes during this Open Season do not need to take any action.

Employees wishing to enroll or make any changes in their enrollment must complete the appropriate enrollment forms. These forms are available from MiCare office in Kolonia and at the branch offices in each state. The form must be completed and submitted to the same office by the close of business on July 31, 2006.

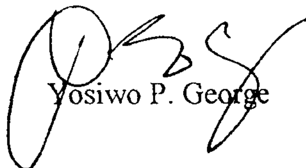
New enrollments and changes elected during the Open Season will become effective October 1, 2006.

Identification cards will be issued after new enrollments and changes are effected & filed at the MiCare office in Kolonia, Pohnpei.

Should you have any questions, please contact MiCare office or at the following telephone numbers:

Pohnpei ....320-2549, contact person, Christina James
Kosrae........................370-3199, contact person, Sepe Jackson
Chuuk........................330-5891, contact person, Marcelly Osawa
Yap...........................350-2307, contact person, Elizabeth Rutnag

Thank you



Yosiwo P. George