



**Appendix CC.**  
**FSM MiCare PLAN**  
**P.O Box 2156**  
**Kolonia, Pohnpei FM 96941**

AMENDMENT OF ENROLLMENT

I \_\_\_\_\_ with Insurance ID# \_\_\_\_\_  
 employed at \_\_\_\_\_ would like to request your office to  
 make the following amendments to my enrollment including my dependents in the FSM MiCare Plan. I am currently residing in \_\_\_\_\_  
 My Mailing address is \_\_\_\_\_  
 My Telephone is: Home \_\_\_\_\_ Office: \_\_\_\_\_

**A. CHANGES OF OPTION**

Name of Member	Amended		Residency
	From	To	
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

**B. ADDITIONAL DEPENDENT(s)**

Name of Member	Options	Sex	Relationship	Birthdate	Residency
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

**C. DELETION OF DEPENDENT(s)**

Name of Member	Reason for Deletion
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

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

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

\_\_\_\_\_  
 Signature of Enrollee \_\_\_\_\_  
 Date

**FOR OFFICIAL USE ONLY**

EFFECTIVE DATE	TOTAL PREMIUM CONTRIBUTION	INCREASE BY _____
		DECREASE BY _____