CNMI Department of Finance
Group Health& Life Insurance Trust Fund
P.O. Box 5234 CHRB Saipan, MP 96950
Tel. (670) 664-5455
Email: GHLI@dof.gov.mp

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

2026 ENROLLMENT / WAIVER / CHANGE REQUEST

Employee / Retiree/ Surviving Spouse Completes Sections A-E

EMPLOYEE / RETIREE / SURIVIVING SPOUSE INFORMATION

Last Name, First Name, Middle Initial	Social Security Number	Date of Birth (MM/DD/YY)	Gender (M/F)

Mailing Address	Contact 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 — Date of Hire: _____

Retirement—must be enrolled prior to retirement — Date of Retirement: _____

Surviving Spouse — Date Benefits Began: _____

CHANGE:

- ☐ Add Spouse
- ☐ Add Dependent Child
- ☐ Add Domestic Partner
- ☐ Name Change
- ☐ Change of Dept. or Division
- ☐ 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 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	☐ $121.23	☐ $65.34	☐ $37.81	☐ $111.90	☐ $60.32	☐ $34.90
Employee + Spouse or One Dependent	☐ $248.51	☐ $133.95	☐ $77.53	☐ $229.39	☐ $123.64	☐ $71.56
Employee + Family	☐ $387.93	☐ $209.08	☐ $121.01	☐ $358.09	☐ $193.00	☐ $111.70

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

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

E. Medicare Information

Medicare ID Number	Last Name	First Name	Gender

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
- ☐ Driver's License / Passport / Municipality ID / Military ID

2) **Authorization for automatic payroll or retirement pension deduction:** The CNMI Government, the NMI Retirement Fund, NMI Settlement Fund or any Autonomous Agency participating in the GHLI program 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, Acknowledgment 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 re-insurer 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:
APPLICATION DISPOSITION ☐ APPROVED ☐ DISAPPROVED ☐ COMMMENTS:_____	
Plan Administrator's Name/Signature:	Date: