



**DEPARTMENT OF
ADMINISTRATION**
DIPATTAMENTON ATMENESTRASION
DIVISION OF ACCOUNTS
(Dibision Kuenta)

Telephone (Telifon): (671) 475-1217 • Fax (Faks): (671) 472-8483



AUTHORIZATION FOR CHARGE ACCOUNT

Name:	Social Security Number:
Department:	Retirement Date:
Status: / / DC Retiree / / Survivor / / LTD - Long Term Disability	Mailing Address:

Please indicate if this is a: / / New Application / / Updated Application
/ / Termination of Deduction

Acct. Holder Name:	Bank Routing Number:
Bank Name:	Bank Account Number:
Choose one method of payment*: / / Checking / / Savings <small>*for Checking: Attach Voided Check or Personalized Deposit Slip for Savings: Attach Copy of most Recent Bank Statement</small> Life Insurance Amount: _____ Health Insurance Amount: _____ TOTAL: _____ Rates are subject to change every Open Enrollment and may increase.	HEALTH Plan Name: _____ Plan Type: / / PPO / / HSA / / RSP Class: / / I / / II / / III / / IV / / Medical / / Dental LIFE / / Voluntary Life Ins. Add'l \$ _____ / / Dependent Coverage

By signing below, I authorize the Department of Administration to process the indicated selection. I agree to contact DOA at least 10 working days before the due date with any concerns or to allow time for corrections.

The deductions are for the Health/Life Insurance Coverage under the Government of Guam's Insurance Program for eligible DC retirees, survivors and Long-Term Disability Members. **Deductions will occur every 20th of the month and will be a recurring deduction.** Once enrolled, I cannot cancel my coverage until the next Open Enrollment Period, unless authorized by the plan contract terms and conditions. In the event a NSF occurs, DOA will terminate services for deduction and the Health/Life plan may terminate coverage due to non-payment.

Rates may increase during the annual Open Enrollment Period. **Premiums will continue at the new rate unless an Authorization for Charge Account is completed to terminate the deduction.**

Signature/Date	Phone No.	Email Address
----------------	-----------	---------------

DOA Acknowledged: Employee Initials _____ Effective Date _____

ACC-INS001 Form Revised 09/2020