

GIC MUNICIPAL ENROLLMENT/CHANGE FORM (FORM-1MUN)

Health Insurance



Commonwealth of Massachusetts
Group Insurance Commission

REQUIRED INFORMATION							
REQUIRED	Insured Information	GIC-ID (usually Soc. Sec. #) - -		Sex <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth / /	Dept. ID # or Agency/Division # /	
		Name – Last		First		MI	
REQUIRED	Address	Street			City	State	Zip
		Home or Cell Phone ()	Work Phone ()	Email		Country (if not USA)	
REQUIRED	Employment Information	Date of Hire (must be completed): / /		Name of Municipality:			

REQUIRED FOR ALL NEW ENROLLMENTS					
REQUIRED	For Agency Use Only	Does the employee participate in a public retirement system? <input type="checkbox"/> Yes <input type="checkbox"/> No		Check one: <input type="checkbox"/> Full-time <input type="checkbox"/> Part-time	Number of work hours/week:

REQUIRED	Select all that apply:	Qualifying Status Change	Date of Event: ___ / ___ / _____
	<input type="checkbox"/> New Enrollment <input type="checkbox"/> Adding Dependent(s) <input type="checkbox"/> Dropping Dependent(s) <input type="checkbox"/> Decline GIC health insurance coverage	<input type="checkbox"/> Annual Enrollment <input type="checkbox"/> Address Change <input type="checkbox"/> Name Change	<input type="checkbox"/> Marriage <input type="checkbox"/> Birth/Adoption <input type="checkbox"/> Divorce/Legal Separation <input type="checkbox"/> Change in Dependent Eligibility Status <input type="checkbox"/> Gain of Other Coverage

HEALTH PLAN				Effective Date: / 01 /	
REQUIRED	Health Plan	<input type="checkbox"/> Fallon Direct (HMO) <input type="checkbox"/> Fallon Select (HMO) <input type="checkbox"/> Harvard Pilgrim Independence (POS) (Closed to New Members) <input type="checkbox"/> Harvard Pilgrim Primary Choice (HMO)	<input type="checkbox"/> Health New England (HMO) <input type="checkbox"/> NHP Prime-Neighborhood Health Plan (HMO) <input type="checkbox"/> Tufts Health Plan Navigator (POS) <input type="checkbox"/> Tufts Health Plan Spirit (HMO-type)	<input type="checkbox"/> UniCare State Indemnity/Basic CIC: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> UniCare Community Choice (PPO-type) <input type="checkbox"/> UniCare/PLUS (PPO-type)	Coverage Election
		<input type="checkbox"/> Individual <input type="checkbox"/> Family			
Cancel Health Insurance Coverage: <input type="checkbox"/> Yes <input type="checkbox"/> No					

SPOUSE/DEPENDENT INFORMATION (See instructions on back)							
For Changes Only	LAST NAME	FIRST NAME	MI	SSN (REQUIRED)	DATE OF BIRTH	SEX	RELATIONSHIP
<input type="checkbox"/> Add <input type="checkbox"/> Drop					/ /	<input type="checkbox"/> M <input type="checkbox"/> F	
<input type="checkbox"/> Add <input type="checkbox"/> Drop					/ /	<input type="checkbox"/> M <input type="checkbox"/> F	
<input type="checkbox"/> Add <input type="checkbox"/> Drop					/ /	<input type="checkbox"/> M <input type="checkbox"/> F	
<input type="checkbox"/> Add <input type="checkbox"/> Drop					/ /	<input type="checkbox"/> M <input type="checkbox"/> F	
<input type="checkbox"/> Add <input type="checkbox"/> Drop					/ /	<input type="checkbox"/> M <input type="checkbox"/> F	

FORMER SPOUSE INFORMATION – If Listed Above				Date of Divorce: / /
Are you remarried? <input type="checkbox"/> Yes <input type="checkbox"/> No	Date of your remarriage: / /	Has your former spouse remarried? <input type="checkbox"/> Yes <input type="checkbox"/> No	Date of former spouse's remarriage: / /	
Address: Street		City	State	Zip

SIGNATURE REQUIRED	AUTHORIZATION – I have read the instructions on the reverse side of this form and authorize my employer, or direct my pension authority, to deduct from my payroll or pension check the amount required for the coverage I have selected. I understand that due to IRS regulations, my health insurance coverage elections are binding for the duration of the plan year and that I may only enroll in health insurance or change my coverage elections during the plan year if I experience a qualifying status change (examples include marriage, adoption/birth of a child, death of a dependent, and involuntary loss of coverage). I understand that the GIC must receive any required documentation for health insurance changes within 60 days of the event.			
	Signature of Applicant: _____		Date: _____	
Signature of Authorized Official: _____		Date: _____		

For GIC Use Only	Entered	Verified	Political Subdivision
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(See over for Form-1MUN instructions)

MUNICIPAL ENROLLMENT/CHANGE FORM (FORM-1MUN) INSTRUCTIONS

For an overview of your GIC benefit options, see your GIC Benefit Decision Guide mass.gov/gic/bdgs.

Deadlines and Required Documentation

- **Required Documentation:** To add a spouse or dependent to coverage, documentation is required. Refer to dependent information section below for details.
- **New Hire:** Completed paperwork and required documentation must be received by your GIC Coordinator no later than your 10th calendar day of regular, benefit eligible employment.
- **Annual Enrollment:** Completed paperwork and required documentation must be received by your GIC Coordinator by the end of the Annual Enrollment period.
- **Qualifying Status Change for Health Insurance:** Municipal employees and retirees who have a qualified status change during the year can enroll in GIC health insurance or change from individual to family or family to individual coverage with proof of the family status change. Documentation of the event and the completed form must be received at the GIC within 60 days of the qualifying event. Forms received after 60 days are returned and you may re-apply during Annual Enrollment.
- **Return from FMLA or Military Leave:** If you voluntarily canceled GIC health insurance coverage at the beginning of your FMLA or military leave of absence, you can re-enroll in GIC health insurance coverage upon your return from leave. The enrollment form must be received at the GIC within 60 days of the return to work. Forms received after 60 days are returned and you may re-apply during Annual Enrollment.

Work Hours and Eligibility

Active municipal employees must work at least 18.75 hours in a 37.5-hour workweek or 20 hours in a 40-hour workweek and must contribute to your employer's public sector retirement system. For GIC purposes, OBRA is not such a retirement system. For additional eligibility details, refer to the GIC's Regulations: mass.gov/gic/regulations.

Dependent Information and Required Documentation

In order to enroll your eligible spouse, former spouse and/or dependents in GIC health insurance, you must enter their information in the spouse/dependent box and provide a copy of a marriage certificate, birth certificate or hospital announcement letter (newborns only), separation agreement, divorce decree, certificate of appointment as legal guardian, etc., for each person you list as a dependent. If covering a former spouse, also complete the former spouse information section. Failure to provide required documentation with this enrollment/change form will result in your spouse/dependent not being covered. If you are deleting a spouse or dependent under age 19, you must provide proof of other health insurance coverage. Under federal health care reform, Social Security Numbers must be provided for each spouse/dependent to be covered under the health plan. For a newborn only, the Social Security Number can be provided at a later date. Please indicate the exact date of birth for each dependent. To cover a dependent age 19 to 26, you must also provide a completed Dependent Age 19 to 26 Enrollment and Change Form.

Form and Documentation Submission

Incomplete forms and insufficient required documentation may result in no coverage or a delayed effective date.

Active Employees: Return completed form and documentation to your GIC Coordinator.

(See over for Form-1MUN)