

# GIC DENTAL/VISION ENROLLMENT/CHANGE FORM (FORM-1DV)



Employees subject to collective bargaining, in higher education, the judicial trial court system, municipalities and authorities are not eligible for GIC Dental/Vision.

REQUIRED INFORMATION							
<b>REQUIRED</b>	<b>Insured Information</b>	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		
<b>REQUIRED</b>	<b>Address</b>	Street			City	State	Zip
		Home or Cell Phone ( )	Work Phone ( )	Email		Country (if not USA)	
<b>REQUIRED</b>	<b>Employment Information</b>	Confidential Employee (check one) <input type="checkbox"/> Yes <input type="checkbox"/> No		HR/CMS Employee ID #	Number of work hours/week:	Date of Hire / /	

<b>REQUIRED</b>	<b>Select all that apply:</b>	<b>Qualifying Status Change</b>	Date of Event: ____ / ____ / ____
	<input type="checkbox"/> New Enrollment (New Eligibility) <input type="checkbox"/> Adding Dependent(s) <input type="checkbox"/> Dropping Dependent(s) <input type="checkbox"/> Address Change <input type="checkbox"/> Name Change <input type="checkbox"/> Annual Enrollment <input type="checkbox"/> Promotion	<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 <input type="checkbox"/> Involuntary Loss of Other Coverage <input type="checkbox"/> Death of spouse/dependent <input type="checkbox"/> Spouse's Annual Enrollment

DENTAL AND VISION PLAN			Effective Date:
<b>Dental Benefit</b> (check one) <input type="checkbox"/> Indemnity Plan (Classic) <input type="checkbox"/> PPO Plan (Value)	<b>Vision Benefit</b> (contact the vendor for participating providers)	<b>Coverage Election</b> (check one) <input type="checkbox"/> Individual <input type="checkbox"/> Family	<b>Cancel</b> <input type="checkbox"/> GIC Dental/Vision Coverage

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			
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

<b>SIGNATURE REQUIRED</b>	<b>AUTHORIZATION</b>
	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 my coverage elections are binding for the duration of the plan year and that I may only enroll in coverage during the plan year if I experience a qualifying status change, (examples include marriage, adoption/birth of a child, divorce, death of a dependent, and involuntary loss of coverage). I understand that the GIC must receive any required documentation within 60 days of the event.
	Signature of Applicant: _____ Date: _____ Signature of Authorized Official: _____ Date: _____

<b>For GIC Use Only</b>	Entered	Verified	Political Subdivision
-------------------------	---------	----------	-----------------------

(See over for Form-1DV instructions)

# GIC DENTAL AND VISION ENROLLMENT/CHANGE FORM (FORM-1DV) INSTRUCTIONS

For an overview of your GIC benefit options, see your GIC Benefit Decision Guide [www.mass.gov/gic/bdgs](http://www.mass.gov/gic/bdgs).

## Eligibility

The GIC Dental/Vision Plan is for state employees who are not covered by collective bargaining or do not have another Dental and Vision Plan through the state. The plan primarily covers managers, Legislators, Legislative staff, confidential employees, and certain Executive Office and MBTA staff. Employees of authorities, municipalities, higher education, and the Judicial Trial Court system are not eligible for GIC Dental/Vision coverage and should not complete this form. Eligible active state employees must work at least 18.75 hours in a 37.5-hour workweek or 20 hours in a 40-hour workweek.

## Deadlines and Required Documentation

- **Required Documentation:** To add a spouse or dependent to coverage, documentation is required to accompany the form unless you have already provided it to the GIC for health insurance coverage. 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 10<sup>th</sup> 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:** State employees enrolling in Dental/Vision or changing from individual to family or family to individual coverage due to a qualifying event must complete and return the form and attach supporting documentation for the qualifying event. Forms and documentation must be received at the GIC within 60 days of the qualifying event. Forms and documentation received after 60 days are returned and you may re-apply during Annual Enrollment.

## Dependent Information and Required Documentation

In order to enroll your eligible spouse, former spouse and/or dependents in GIC Dental/Vision, you must enter their information in the spouse/dependent information box and provide a copy of a marriage certificate, birth certificate, 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 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 coverage. 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 Form.

## Enrolling in or Changing Coverage

If you do not enroll in the GIC Dental/Vision Plan as a new hire or when first eligible, you will not be able to enroll until the next annual enrollment period, unless you have a qualifying event. You can only change dental plan type during annual enrollment.

If you withdraw from the plan or are terminated because of non-payment of premium, you will be unable to re-enroll in the plan until July 1 following 24 months from the date your coverage ended.

## Form and Documentation Submission

Return completed form and documentation to your GIC Coordinator.

*(See over for Form-1DV)*