

GIC INITIAL MUNICIPAL EMPLOYEE ENROLLMENT FORM (FORM-IME) Health Insurance



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					
	Address	Street			City	State	Zip
	Contact Information	Home or Cell Phone ()	Work Phone ()	Email		Country (if not USA)	
	Employment Information	Date of Hire (must be completed): / /		Name of Municipality:			

REQUIRED FOR ALL NEW ENROLLMENTS			
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 one: <input type="checkbox"/> New Enrollment <input type="checkbox"/> Decline GIC health insurance coverage <input type="checkbox"/> Cancel Coverage	<input type="checkbox"/> COBRA Enrollee COBRA Expiration Date / /
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HEALTH PLAN				Effective Date: / 01 /
Health Plan	<input type="checkbox"/> Fallon Direct (HMO)	<input type="checkbox"/> Health New England (HMO)	<input type="checkbox"/> UniCare State Indemnity/Basic	Coverage Election <input type="checkbox"/> Individual <input type="checkbox"/> Family
	<input type="checkbox"/> Fallon Select (HMO)	<input type="checkbox"/> NHP Prime–Neighborhood Health Plan (HMO)	CIC: <input type="checkbox"/> Yes <input type="checkbox"/> No	
	<input type="checkbox"/> Harvard Pilgrim Independence (POS) (Closed to New Members)	<input type="checkbox"/> Tufts Health Plan Navigator (POS)	<input type="checkbox"/> UniCare Community Choice (PPO-type)	
	<input type="checkbox"/> Harvard Pilgrim Primary Choice (HMO)	<input type="checkbox"/> Tufts Health Plan Spirit (HMO-type)	<input type="checkbox"/> UniCare/PLUS (PPO-type)	

SPOUSE/DEPENDENT INFORMATION							
	LAST NAME	FIRST NAME	MI	SSN (REQUIRED)	DATE OF BIRTH	SEX	RELATIONSHIP
<input type="checkbox"/> Add					/ /	<input type="checkbox"/> M <input type="checkbox"/> F	
<input type="checkbox"/> Add					/ /	<input type="checkbox"/> M <input type="checkbox"/> F	
<input type="checkbox"/> Add					/ /	<input type="checkbox"/> M <input type="checkbox"/> F	
<input type="checkbox"/> Add					/ /	<input type="checkbox"/> M <input type="checkbox"/> F	
<input type="checkbox"/> Add					/ /	<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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