Commonwealth of Massachusetts
Group Insurance Commission

P.O. Box 8747 • BOSTON, MA 02114-8747
(617) 727-2310 www.mass.gov/gic

Initial Municipality Insurance Enrollment Form – Medicare Retirees

01 ☐

Insured's GIC-ID (usually Soc. Sec. #)	Sex: Male ☐ Female ☐	Date of Birth	Dept. ID # or Agency/Division #
— —		/ /	666/

Name - Last First MI

Address | City | State | Zip Code

Home Phone ( ) Work Phone ( )

02 ☐ **HEALTH COVERAGE** **Effective Date: / 01 /**

New Enrollment ☐ **Decline Coverage** ☐

☐ **Health** (Select one of the health plans below and individual or family coverage)

Health Plan – Medicare Retirees

☐ **Fallon Senior Plan** ☐ **Harvard Pilgrim Medicare** ☐ **Health New England MedPlus**

☐ **Tufts Medicare Complement** ☐ **Tufts Medicare Preferred**

If enrolling in one of these five plans, complete the Plan's enrollment form and send it to the Plan

☐ **UniCare State Indemnity Plan / Medicare Extension (OME)** CIC: ☐ Yes ☐ No

Coverage
☐ **Individual**
☐ **Family**

SPOUSE/DEPENDENT INFORMATION

List below all family members, including your spouse, who will be covered under your health plan. Married children are not eligible. Attach a seperate sheet if additional space is required. Please provide all Social Security Numbers and exact dates of birth for each dependent. Coverage for children ends at age 19; to continue their coverage you must complete and return to the GIC a Dependent Age 19 and Over Application for Coverage. **Important:** The Group Insurance Commission reserves the right to require you to provide a copy of a marriage certificate, birth certificate, certificate of appointment as legal guardian, etc., for each person you list as a dependent. This proof may be requested at any time.

Last Name	First	Middle	Relationship	Date of Birth	Sex	Social Security Number

Reason for addition or deletion: _____ Effective date: _____

SPOUSE INFORMATION

Is your spouse employed? ☐ Yes ☐ No Name of employer _____ Address of employer _____

Is your spouse covered under his or her employer's group health insurance plan? ☐ Yes ☐ No Name of insurance company _____

Policy/Certificate Number_____ Address of insurance company_____

Are you and/or your children covered under your spouse's group health insurance plan? You: ☐ Yes ☐ No Children: ☐ Yes ☐ No

Is your spouse enrolled in Medicare? ☐ Yes ☐ No If yes, Medicare claim number_____

FORMER SPOUSE

Name _____ Social Security Number _____ Date of Birth _____ Date of Divorce _____

Last First Middle

Address _____

Street City State Zip Code

Is your former spouse employed? ☐ Yes ☐ No Name of employer _____

Is your former spouse covered under his or her employer's group health insurance plan? ☐ Yes ☐ No

SIGNATURE REQUIRED

x _____ Signature of Applicant Date

x _____ Signature of Authorized Official Date

FOR GIC USE ONLY:	Entered	Verified	Political Subdivision