



Initial Municipality Insurance Enrollment Form – Active Employees and Non-Medicare Retirees

<input type="checkbox"/> 01	Insured's GIC-ID (usually Soc. Sec. #) ____ - ____ - ____	Sex: Male <input type="checkbox"/> Female <input type="checkbox"/>	Date of Birth / /	Dept. ID # or Agency/Division # 666/
Name - Last		First		MI
Address		City		State
		Home Phone ()		Work Phone ()

<input type="checkbox"/> 02	HEALTH COVERAGE	Effective Date: / 01 /
New Enrollment <input type="checkbox"/>	Decline Coverage <input type="checkbox"/>	

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

Health Plan – Active Employees and Non-Medicare Retirees

<input type="checkbox"/> Fallon Direct	<input type="checkbox"/> Navigator by Tufts Health Plan	<input type="checkbox"/> UniCare/Community Choice	<u>Coverage</u> <input type="checkbox"/> Individual <input type="checkbox"/> Family
<input type="checkbox"/> Fallon Select	<input type="checkbox"/> NHP Care – Neighborhood Health Plan (HMO app required)	<input type="checkbox"/> UniCare/PLUS	
<input type="checkbox"/> Harvard Pilgrim Independence	<input type="checkbox"/> UniCare State Indemnity/Basic		
<input type="checkbox"/> Health New England	CIC: <input type="checkbox"/> Yes <input type="checkbox"/> No		

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 separate 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
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FOR GIC USE ONLY:	Entered	Verified	Political Subdivision
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