

# GIC RMT ENROLLMENT FORM (FORM-RMT)



REQUIRED						INSURED INFORMATION					
REQUIRED	Insured Information	GIC-ID (usually Soc. Sec. #) - -			Sex <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth / /	Agency/Division # (GIC use only) /				
		Name – Last			First		MI				
	Address	Street				City		State	Zip		
	Contact Information	Home Phone ( )		Cell Phone ( )		Email		Country (if not USA)			
Claim Number	Insured's Medicare Claim #				Spouse's Medicare Claim #						

Retirement Information	Name of Municipality or school district retired from	Will you receive a monthly pension from a public retirement system? <input type="checkbox"/> Yes <input type="checkbox"/> No	Date of Retirement / /
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HEALTH AND BASIC LIFE			
<input type="checkbox"/> Basic Life Only	<input type="checkbox"/> Basic Life and Health		
<b>MEDICARE PLAN</b> – Select one if you and/or your spouse/covered dependents are enrolled in Medicare.			
<input type="checkbox"/> Tufts Medicare Preferred (HMO)	<input type="checkbox"/> Tufts Medicare Complement (Indemnity)	<b>Medicare Coverage Election</b> <input type="checkbox"/> Individual <input type="checkbox"/> Individual and spouse <input type="checkbox"/> Family	Check all that apply: <input type="checkbox"/> Individual on Medicare <input type="checkbox"/> Spouse on Medicare <input type="checkbox"/> Dependent(s) on Medicare
<input type="checkbox"/> Harvard Pilgrim Medicare Enhance (Indemnity)	<input type="checkbox"/> UniCare State Indemnity Medicare Extension		
<input type="checkbox"/> Health New England Medicare Supplement Plus (Indemnity)	CIC: <input type="checkbox"/> Yes <input type="checkbox"/> No		
<b>NON-MEDICARE PLAN</b> – Select one if you and/or your spouse/covered dependents are not enrolled in Medicare.			
<input type="checkbox"/> AllWays Health Partners Complete (HMO)	<input type="checkbox"/> Harvard Pilgrim Primary Choice (HMO)	<input type="checkbox"/> UniCare State Indemnity/Basic CIC: <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Non-Medicare Coverage Election</b> <input type="checkbox"/> Individual <input type="checkbox"/> Family
<input type="checkbox"/> Fallon Direct (HMO)	<input type="checkbox"/> Health New England (HMO)		
<input type="checkbox"/> Fallon Select (HMO)	<input type="checkbox"/> Tufts Health Plan Navigator (POS)	<input type="checkbox"/> UniCare Community Choice (PPO-type)	
<input type="checkbox"/> Harvard Pilgrim Independence (POS)	<input type="checkbox"/> Tufts Health Plan Spirit (HMO-type)	<input type="checkbox"/> UniCare/PLUS (PPO-type)	

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	

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	<b>AUTHORIZATION</b> – I have read the instructions on the reverse side of this form and direct my pension authority to deduct from my pension check the amount required for the coverage I have selected. I understand that 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 other coverage). I understand that the GIC must receive any required documentation within 60 days of the event. <b>All divorces and remarriages must be reported to the Group Insurance Commission, failure to notify the GIC of a legal separation, divorce, or remarriage can result in financial liability to you.</b>
	Signature of Applicant: _____ Date: _____

CERTIFICATION OF RETIRING TEACHER'S INSURANCE COVERAGE (REQUIRED)	
<b>To be completed by Payroll/Insurance Coordinator at your Municipality/school district.</b>	
I certify that the above applicant is currently covered under our local life and/or health insurance program and will be covered until his/her retirement coverage begins the first day of the third month after the date of retirement. I will notify the Group Insurance Commission if coverage is interrupted before the retirement coverage begins, or if the date of retirement changes.	
Signature: _____	Date: _____
Please Print Name and Position: _____	

For GIC Use Only	Entered	Verified	Political Subdivision
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(See over for instructions)

# GIC RMT ENROLLMENT FORM (FORM-RMT) INSTRUCTIONS

## Eligibility for benefits through the Group Insurance Commission

If you are a retiring teacher from a city, town or school district whose municipality has elected to participate in the GIC's RMT program and will be receiving a pension from the Massachusetts Teachers Retirement System (MTRS), you are eligible to apply for GIC benefits. If you do not elect benefits at retirement, you may apply for GIC benefits during the GIC's annual enrollment, or within 60 days of a qualifying status change (examples include marriage, divorce, or involuntary loss of other coverage).

**IMPORTANT:** To apply, you must have at least basic life insurance and/or health insurance through the GIC participating city/town/school district on the date of your retirement. If you do not have these benefits on the day you retire, you are not eligible to enroll in GIC benefits. If there is a change to your date of retirement, this may affect your eligibility for GIC benefits.

Use this form for enrolling in GIC benefits for the first time at retirement.

**For an overview of your GIC health insurance benefit options, see the GIC Benefit Decision Guide [mass.gov/gic-retiree-benefits](https://mass.gov/gic-retiree-benefits).**

## Deadlines and Required Documentation

- **Required documentation:** To add a spouse or dependent to coverage, documentation is required. Visit our website for the Required Documentation list: [mass.gov/info-details/gic-forms](https://mass.gov/info-details/gic-forms).
- If you and/or your spouse is **Medicare eligible**, the following documentation must accompany this form:
  - Photocopy of your Medicare Card (include a copy of spouse's card if applicable).
  - Photocopy of your latest 1099 or the Benefit Verification letter printed from Social Security's website stating how your monthly Part B premium is paid (e.g., you are being directly billed by Social Security or it is being deducted from your Social Security check). Include this same documentation for your spouse, if applicable.
- If you and/or your spouse are over age 65 and **not eligible for Medicare**, the following must accompany this form:
  - Social Security Denial letter stating that you and/or your spouse are not eligible for Medicare Part A for free.

## Retiree and Spouse Coverage if Under and Over Age 65

If you (the retiree), your spouse or other covered dependent is younger than age 65, the person or people under age 65 will continue to be covered under a Non-Medicare plan until you and/or he/she becomes eligible for Medicare. When selecting your plan, be sure to choose "individual" Non-Medicare coverage if only covering one Non-Medicare family member; select "family" Non-Medicare coverage if covering two or more Non-Medicare family members.

If enrolling in one of GIC's Medicare Plans, you will be automatically enrolled in the GIC's SilverScript Medicare Part D prescription drug plan. After your enrollment is processed by the GIC, you will receive a mailing from SilverScript with information about the plan and advising you that you have the choice to opt out of the prescription drug plan. The opt-out letter is required by Medicare, but we do not recommend that you do so because **if you opt out of SilverScript, you will lose your GIC medical, prescription drug and behavioral health coverage.**

Your health insurance election includes basic life insurance (this amount is determined by your city/town/school district). Please be sure to complete and include GIC Beneficiary Form - Form 319 (*one to three beneficiaries*) or G-500 (*four or more beneficiaries or special designations, such as estate or trust*) with your enrollment form.

If electing GIC Retiree Dental, the Retiree Dental Enrollment/Change Form (RD) must also be completed.

## Coverage Effective Date

You should apply for coverage two months before your retirement date. Coverage begins on the first day of the third month following your retirement date. For example, if you retire on any day in June, your coverage begins on September 1st. If you have questions about your coverage after your retirement and before your effective date with the GIC, contact your city/town/school district. **Note: The GIC cannot process your application until we have been notified by the Teachers' Retirement Board that you have received your first pension check.**

## Form and Document Submission

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

**ONLINE:** Visit [bit.ly/myGICLink](https://bit.ly/myGICLink) to request and submit your enrollment form(s).

**MAIL:** Return completed form and documentation to the Commonwealth of Massachusetts-Group Insurance Commission, PO Box 556, Randolph, MA 02368.