

RETIRED MUNICIPALTEACHER ENROLLMENT (FORM-RMT)

Health and Basic Life Insurance



REQUIRED 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	Preferred Phone ()	Preferred 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 / /	

HEALTH AND BASIC LIFE			
<input type="checkbox"/> Basic Life Only	<input type="checkbox"/> Basic Life and Health		
MEDICARE PLAN – Select ONLY ONE if you and/or your spouse/covered dependents are enrolled in Medicare			
Massachusetts, New England & Nationwide Residents: <input type="checkbox"/> Harvard Pilgrim Medicare Enhance (Supplement) <input type="checkbox"/> Health New England Medicare (Supplement) <input type="checkbox"/> Wellpoint Medicare Extension (Supplement)	Massachusetts Residents (limited service area): <input type="checkbox"/> Tufts Medicare Preferred (Advantage)* <small>* Contact plan for Massachusetts service area and provider network information.</small>	Medicare Coverage Election <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
NON-MEDICARE PLAN – Select ONLY ONE if you and/or your spouse/covered dependents are not enrolled in Medicare			
Massachusetts Residents <input type="checkbox"/> Harvard Pilgrim Quality (HMO) <input type="checkbox"/> Health New England (HMO) <input type="checkbox"/> Mass General Brigham Health Plan Complete (HMO) <input type="checkbox"/> Wellpoint Community Choice (PPO-TYPE)	Massachusetts & New England Residents: <input type="checkbox"/> Harvard Pilgrim Explorer (POS) <input type="checkbox"/> Wellpoint Total Choice (Indemnity) <input type="checkbox"/> Wellpoint Plus (PPO-TYPE)	Nationwide excluding New England Residents: <input type="checkbox"/> Harvard Pilgrim Access America (PPO)	Non-Medicare Coverage Election: <input type="checkbox"/> Individual <input type="checkbox"/> Family

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			
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
Date of Divorce: / /			

SIGNATURE REQUIRED	AUTHORIZATION – 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. If premiums are not deducted enrolled members will receive a monthly bill for premiums due. 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 event (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. You must notify the GIC of a legal separation, divorce or remarriage of you or your former spouse; coverage for a former spouse ends upon remarriage. Failure to notify the GIC can result in financial liability to you. Signature of Applicant: _____ Date: _____ This form may only be signed by the employee/retiree or someone with legal authority to sign on behalf of the employee/retiree.
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CERTIFICATION OF RETIRING TEACHER'S INSURANCE COVERAGE (REQUIRED)	
To be completed by Payroll/Insurance Coordinator at your Municipality/school district. 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 Title: _____	

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 event (examples include marriage, divorce, or involuntary loss of other coverage). **For an overview of your GIC benefit options, see your GIC Benefit Guide at mass.gov/GIC.**

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.

Coverage Effective Date

GIC recommends that you apply for coverage two months before your official retirement date. If your application is not received within 60 days of your official retirement date, your application will be denied. GIC 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. Please note that if you and/or your spouse are eligible for Medicare, enrollment in Medicare Part A (for free) and Part B is required and must be in effect on the day that you are eligible for GIC health coverage. You must contact the Social Security Administration to apply to enroll in Medicare Part A and B.

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: You must be receiving a monthly pension from the Teachers' Retirement Board in order to be eligible for GIC benefits.

Deadlines and Required Documentation

- To add a spouse or dependent to coverage, documentation is required. Do not send original documents because they will not be returned. Visit our website for the Required Documentation list: mass.gov/info-details/gic-forms.
- If you and/or your spouse is **Medicare eligible**, enrollment in Medicare Part A (for free) and Medicare Part B is required to be eligible for GIC health coverage and must be in effect when you apply; and the following is needed:
 - Indicate your and/or your spouse's Medicare Claim number on the front of this form.
- If you and/or your spouse are over age 65 and **not eligible for Medicare**, the following document must accompany this form:
 - Social Security Denial letter stating that you and/or your spouse are not eligible for Medicare Part A for free.

Prescription Drug Information for Medicare Plan Enrollees

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.**

If you enroll in another non-GIC Medicare Part D plan anytime throughout the year, 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 (Form-RD) must also be completed.

Form and Document Submission

This form may only be signed by the retiree or someone with legal authority to sign on behalf of the retiree. Incomplete forms and insufficient required documentation may result in no coverage or a delayed effective date.

Email completed form to gic.forms@mass.gov or mail to:

Group Insurance Commission
PO Box 556, Randolph, MA 02368.