RETIREE & SURVIVOR ENROLLMENT/CHANGE (FORM-RS)

Health Insurance

This form is intended for use ONLY by GIC members without access to a digital device. GIC members with an up-to-date email address on GIC records received a registration email for the **MyGICLink Member Benefits Portal**. MyGICLink allows GIC members to view their benefits throughout the year and update coverage during Annual Enrollment or if experiencing a qualifying event in just a few minutes. Learn more at **mass.gov/mygiclink**. If you haven't received a MyGICLink registration email, please include your email on this form.

REQUIRED

INSURED INFORMATION

Insured Information	GIC-ID (usually Soc. Sec. #) – –	Sex ☐ M ☐ F	Date of Birth / /	Dept. ID # or Agency/Division # /
	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 State Agency or Municipality retired from	Do you receive a monthly pension from a public retirement system? ☐Yes ☐No	Date of Retirement / /
Survivor Information	Name of Deceased Employee or Retiree	Deceased Employee's/Retiree's Soc. Sec. # - -	Have you remarried? ☐Yes Date of remarriage____/____ /_____ ☐ No

REQUIRED

Select all that apply:

- ☐ New Enrollment
- ☐ Annual Enrollment
- ☐ Adding Dependent(s)
- ☐ Address Change
- ☐ Dropping Dependent(s)
- ☐ Name Change
- ☐ Decline all GIC coverage
- ☐ Cancel GIC health insurance during Annual Enrollment or during a qualifying event

Qualifying Event (Date of Event: ____ / ____ / _____)

- ☐ Marriage
- ☐ Birth/Adoption
- ☐ Divorce/Legal Separation
- ☐ Change in Dependent Eligibility Status
- ☐ Gain of Other Coverage
- ☐ Involuntary Loss of Other Coverage
- ☐ Death of spouse/dependent
- ☐ Spouse's Annual Enrollment
- ☐ Moved out of health plan's service area

MEDICARE PLAN – Select ONLY **ONE** if you and/or your spouse/covered dependents are enrolled in Medicare

Effective Date: / 01/

Massachusetts, New England & Nationwide Residents:

- ☐ Harvard Pilgrim **Medicare Enhance (Supplement)**
- ☐ Health New England **Medicare (Supplement)**
- ☐ Wellpoint **Medicare Extension (Supplement)**

Massachusetts Residents (limited service area):

- ☐ Tufts **Medicare Preferred (Advantage)***

* Contact plan for Massachusetts service area and provider network information.

Medicare Coverage Election

- ☐ Individual
- ☐ Individual and spouse
- ☐ Family

Check all that apply:

- ☐ Individual on Medicare
- ☐ Spouse on Medicare
- ☐ 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:

- ☐ Harvard Pilgrim **Quality (HMO)**
- ☐ Health New England **(HMO)**
- ☐ Mass General Brigham Health Plan **Complete (HMO)**
- ☐ Wellpoint **Community Choice (PPO-TYPE)**

Massachusetts & New England Residents:

- ☐ Harvard Pilgrim **Explorer (POS)**
- ☐ Wellpoint **Total Choice (Indemnity)**
- ☐ Wellpoint **Plus (PPO-TYPE)**

Nationwide excluding New England Residents:

- ☐ Harvard Pilgrim **Access America (PPO)**

Non-Medicare Coverage Election:

- ☐ Individual
- ☐ Family

SPOUSE/DEPENDENT INFORMATION *(See instructions on back)*

For Changes Only	LAST NAME	FIRST NAME	MI	SSN (REQUIRED)	DATE OF BIRTH	SEX	RELATIONSHIP
☐ Add ☐ Drop					/ /	☐ M ☐ F	
☐ Add ☐ Drop					/ /	☐ M ☐ F	
☐ Add ☐ Drop					/ /	☐ M ☐ F	
☐ Add ☐ Drop					/ /	☐ M ☐ F	

FORMER SPOUSE INFORMATION – If Listed Above

Date of Divorce: / /

Are you remarried? ☐ Yes ☐ No	Date of your remarriage: / /	Has your former spouse remarried? ☐ Yes ☐ 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 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 may receive a bill for premiums due from the GIC or participating municipality. 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: _____

Signature of Authorized Official: _____ Date: _____

This form may only be signed by the employee/retiree/survivor or someone with legal authority to sign on behalf of the employee/retiree/survivor.

(See over for Form-RS instructions)

GIC RETIREE/SURVIVOR ENROLLMENT AND CHANGE FORM (FORM-RS) INSTRUCTIONS

Use this Form-RS to make GIC health plan changes for a qualifying event, at Annual Enrollment, and for enrolling in GIC health insurance for the first time at retirement. **Enrolling in health insurance for the first time:** Use this form in addition to Form-1A to enroll at retirement in GIC health insurance for the first time. You must send with this form a copy of the letter from your retirement board approving your retirement. State retirees please note that your health insurance election includes basic life insurance.

For an overview of your GIC benefit options, see your GIC Benefit Guide at mass.gov/GIC

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** and **not already enrolled in GIC Medicare** coverage, the following documentation is needed:
  - Be sure to indicate you 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** and have not already provided the following documentation to the GIC, it must accompany this form:
  - Social Security Denial letter stating that you and/or your spouse are not eligible for Medicare Part A for free.
- **Annual Enrollment:** Completed forms and required documentation must be received by the GIC by the end of the Annual Enrollment period.
- **Qualifying Event:** Completed forms and required documentation must be received by the GIC within 60 days the qualifying event (e.g., marriage or divorce).

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.

Tufts Medicare Preferred (TMP) Members: If canceling or changing from the TMP plan to another GIC Medicare option, you must also submit the Medicare Advantage Plan/Disenrollment form to the GIC.

Form and Document Submission –
Effective dates of coverage cannot be changed after coverage election has been made and submitted to GIC. 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

(See over for Form-RS)