# RETIREE DENTAL ENROLLMENT/CHANGE (FORM-RD)

**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)* |

| | | | |
|---|---|---|---|
| **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 (New Eligibility)
- ☐ Adding Dependent(s)
- ☐ Dropping Dependent(s)
- ☐ Address Change
- ☐ Name Change
- ☐ Annual Enrollment

**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

## RETIREE DENTAL

Effective Date: / 01 /

**Coverage Election** (check one) ☐ Individual ☐ Family

**Cancel** ☐ GIC Retiree Dental Coverage

- If you do not sign up for coverage within 60 days of retirement, you will not be able to enroll until the next annual enrollment period, unless you involuntarily lose dental coverage during the year or have a qualifying status change and apply within 60 days of the event.
- If you sign up for coverage and decide to cancel, you can never rejoin the plan.
- If you have family coverage and switch to an individual plan, your spouse and/or your eligible dependents can never rejoin the plan.

List below all family members, including your spouse, who will be covered under your dental plan. Please provide all Social Security Numbers and exact dates of birth for each dependent. The Group Insurance Commission requires you to provide a copy of a marriage certificate, birth certificate, legal separation, divorce decree, or certificate of appointment as legal guardian for each person you list as a dependent. Do not send original documents because they will not be returned.

## SPOUSE/DEPENDENT INFORMATION

| 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 | |
| ☐ 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 above 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 coverage elections are binding for the duration of the plan year and that I may only enroll in or change my coverage elections during the plan year if I experience a qualifying status change (examples include marriage, adoption/birth of a child, divorce, 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 authorized by the GIC to sign on the employee/retiree's behalf.**

**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.

**ONLINE:** Visit bit.ly/giconlineforms to request and submit your enrollment form(s).

**MAIL:** Mail completed form to the GIC:

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