

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			
REQUIRED	Insured Information	GIC-ID (usually Soc. Sec. #)		Sex <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth / /		Dept. ID # or Agency/Division # /
		Name – Last		First		MI	
	Address	Street			City		State Zip
REQUIRED	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? <input type="checkbox"/> Yes <input type="checkbox"/> No		Date of Retirement / /	
REQUIRED	Survivor Information	Name of Deceased Employee or Retiree		Deceased Employee's/Retiree's Soc. Sec. # - -		Have you remarried? <input type="checkbox"/> Yes Date of remarriage ___/___/___ <input type="checkbox"/> No	
	Select all that apply: <input type="checkbox"/> New Enrollment <input type="checkbox"/> Annual Enrollment <input type="checkbox"/> Address Change <input type="checkbox"/> Adding Dependent(s) <input type="checkbox"/> Dropping Dependent(s) <input type="checkbox"/> Name Change		Qualifying Event (Date of Event: ___/___/___) <input type="checkbox"/> Marriage <input type="checkbox"/> Birth/Adoption <input type="checkbox"/> Divorce/Legal Separation <input type="checkbox"/> Change in Dependent Eligibility Status <input type="checkbox"/> Gain of Other Coverage <input type="checkbox"/> Involuntary Loss of Other Coverage <input type="checkbox"/> Death of spouse/dependent <input type="checkbox"/> Spouse's Annual Enrollment				

RETIREE DENTAL		Effective Date: / 01 /
Coverage Election (check one) <input type="checkbox"/> Individual <input type="checkbox"/> Family		Cancel <input type="checkbox"/> GIC Retiree Dental Coverage
<ul style="list-style-type: none"> 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 event 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
<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	
<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
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 event (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 with legal authority to sign on behalf of the employee/retiree.

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.