TUFTS MEDICARE PREFERRED DISENROLLMENT FORM

Commonwealth of Massachusetts
Group Insurance Commission

Insured must complete this section:

Please disenroll me from the Tufts Medicare Preferred Plan.

GIC ID No. _____

Name: _____
(Please print)

_____ _____
Signature of Insured Date

Spouse, if applicable, must complete this section:

I am the spouse of GIC Insured, _____, and wish to disenroll from the Tufts Medicare Preferred Plan.
(Please print)

Name: _____ GIC ID No. _____
(Please print)

_____ _____
Signature of Spouse Date

Medicare Dependent, if applicable, must complete this section:

I am the dependent of GIC Insured, _____, and wish to disenroll from the Tufts Medicare Preferred Plan.
(Please print)

Name: _____ GIC ID No. _____
(Please print)

_____ _____
Signature of Dependent Date

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

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

Mail: Mail completed form to the GIC:
Group Insurance Commission
PO Box 556, Randolph, MA 02368.