

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.

Name: _____
(Please print)

GIC ID No. _____

Signature of Insured

Date

Spouse, if applicable, must complete this section:

I am the spouse of GIC Insured, _____,
(Please print)

Name: _____
(Please print)

GIC ID No. _____

Signature of Spouse

Date

Medicare Dependent, if applicable, must complete this section:

I am the dependent of GIC Insured, _____,
(Please print)

Name: _____
(Please print)

GIC ID No. _____

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