

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.

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.