

# GIC MUNICIPAL RETIREE DENTAL ENROLLMENT/ CHANGE FORM (FORM-MRD)



| REQUIRED INSURED INFORMATION |                     |                                     |                   |                                                              |                      |                                      |
|------------------------------|---------------------|-------------------------------------|-------------------|--------------------------------------------------------------|----------------------|--------------------------------------|
| REQUIRED                     | Insured Information | GIC-ID (usually Soc. Sec. #)<br>- - |                   | Sex<br><input type="checkbox"/> M <input type="checkbox"/> F | Date of Birth<br>/ / | Dept. ID # or Agency/Division #<br>/ |
|                              |                     | Name – Last                         |                   | First                                                        |                      | MI                                   |
| REQUIRED                     | Address             | Street                              |                   | City                                                         |                      | State Zip                            |
|                              |                     | Home Phone<br>( )                   | Cell Phone<br>( ) | 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<br>/ /                                                                                            |
| Survivor Information   | Name of Deceased Employee or Retiree              | Deceased Employee's/Retiree's Soc. Sec. #<br>- -                                                                           | Have you remarried?<br><input type="checkbox"/> Yes Date of remarriage ____/____/____<br><input type="checkbox"/> No |

|          |                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                  |
|----------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| REQUIRED | <b>Select all that apply:</b><br><input type="checkbox"/> New Enrollment (New Eligibility)<br><input type="checkbox"/> Adding Dependent(s) <input type="checkbox"/> Dropping Dependent(s)<br><input type="checkbox"/> Other Benefit Changes <input type="checkbox"/> Address Change<br><input type="checkbox"/> Annual Enrollment <input type="checkbox"/> Name Change | <b>Qualifying Status Change</b><br><input type="checkbox"/> Marriage<br><input type="checkbox"/> Birth/Adoption<br><input type="checkbox"/> Divorce/Legal Separation<br><input type="checkbox"/> Change in Dependent Eligibility Status | Date of Event: ____ / ____ / ____<br><input type="checkbox"/> Gain of Other Coverage<br><input type="checkbox"/> Involuntary Loss of Other Coverage<br><input type="checkbox"/> Death of spouse/dependent<br><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 |
| • 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.<br>• If you sign up for coverage and decide to cancel, you can never rejoin the plan.<br>• 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. Coverage for children ends at age 19; to continue their coverage, complete and return to the GIC a Dependent Age 19 to 26 Enrollment Form if not already submitted for GIC health insurance. The Group Insurance Commission requires you to provide a copy of a marriage certificate, legal separation, divorce decree, or certificate of appointment as legal guardian for each person you list as a dependent.

| 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?<br><input type="checkbox"/> Yes <input type="checkbox"/> No | Date of your remarriage:<br>/ / | Has your former spouse remarried?<br><input type="checkbox"/> Yes <input type="checkbox"/> No | Date of former spouse's remarriage:<br>/ / |                                     |
| Address: Street                                                                |                                 | City                                                                                          | State                                      | Zip                                 |

|                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |          |                       |
|--------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------|-----------------------|
| SIGNATURE REQUIRED | <b>AUTHORIZATION</b> – I have read the instructions on this form and direct my pension authority to deduct from my pension check the amount required for the coverage I have selected. 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, 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. |          |                       |
|                    | Signature of Applicant: _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |          | Date: _____           |
|                    | Signature of Authorized Official: _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |          | Date: _____           |
| For GIC Use Only   | Entered                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | Verified | Political Subdivision |

(See over for mailing instructions and agency/division #)

## RETURN COMPLETED RETIREE DENTAL FORM TO YOUR MUNICIPAL BENEFITS OFFICE

**666/0178 City of Melrose**

Polina Latta  
HR Manager  
562 Main Street  
Melrose, MA 02176  
(781) 979-4145

**666/0014 Town of Ashland**

Susan Huwe  
Assistant Treasurer  
101 Main Street  
Ashland, MA 01721  
(508) 881-0100 x7926

**666/0023 Town of Bedford**

Sarah Buhler  
HR/Management Analyst  
10 Mudge Way  
Bedford, MA 01730  
(781) 687-6181

**666/0046 Town of Brookline**

Scott O'Shea  
Benefits Coordinator  
333 Washington St.  
Brookline, MA 02445  
(617) 730-2134

**666/0133 Town of Holbrook**

Jack Hoell  
Assistant Treasurer  
50 N. Franklin Street  
Holbrook, MA 02343-1560  
(781) 353-5557

**666/0138 Town of Hopedale**

Stephanie L'Etalien  
Treasurer  
78 Hopedale Street  
Hopedale, MA 01747  
(508) 634-2203 x218

**666/0168 Town of Marblehead**

Dianne Rodgers  
Benefits Coordinator  
Mary Alley Municipal Building  
7 Widger Road  
Marblehead, MA  
(781) 631-1705

**666/0182 Town of Middleborough**

Judy MacDonald  
Treasurer/Collector  
20 Centre Street-3rd Floor  
Middleborough, MA 02346  
(508) 946-2420 or 2421

**666/0187 Town of Millis**

Jennifer Scannell  
Treasurer/Collector  
900 Main Street  
Millis, MA 02054  
(508) 376-7091

**666/0210 Town of North Andover**

Karen Robertson  
Benefits Specialist  
120 Main Street  
North Andover, MA 01845  
(978) 380-1010

**666/0244 Town of Randolph**

Cilenia Bevis  
Payroll/Benefits Clerk  
Town Hall  
41 South Main Street  
Randolph, MA 02368  
(781) 961-0911

**666/0291 Town of Swampscott**

Lynn M. Lavoie  
Benefits Coordinator  
Administration Building  
22 Monument Avenue  
Swampscott, MA 01907  
(781) 596-8810

**666/0333 Town of Weston**

Molly Fitzpatrick  
Benefits Coordinator/HR Generalist  
11 Town House Road  
Weston, MA 02493  
(781) 786-5090

**666-0335 Town of Westwood**

Jennifer Kinnear  
HR Administrator  
580 High Street  
Westwood, MA 02090  
(781) 314-1035

**666/0343 Town of Winchendon**

Jillian Lopez  
Assistant Treasurer/Collector  
109 Front St Dept 2  
Winchendon, MA 01475  
(978) 297-0152

**666/0503 Athol-Royalston Reg. School Dist.**

Brenda Butland  
Bookkeeper  
P.O. Box 968  
Athol, MA 01475  
(978) 249-2400

**666/0507 NE Metro Regional Voc. Tech. School**

Tara Calef  
Retiree Insurance Coordinator  
100 Hemlock Road  
Wakefield, MA 01880  
(781) 246-0810 x1636