GIC MUNICIPAL ENROLLMENT/CHANGE FORM (FORM-1MUN)

Health Insurance

Commonwealth of Massachusetts
Group Insurance Commission

REQUIRED

INSURED INFORMATION

Insured Information	GIC-ID (usually Soc. Sec. #) – –	Sex ☐M ☐F	Date of Birth / /	Dept. ID # or Agency/Division # 666 / 0100
	Name – Last	First		MI
Address	Street	City	State	Zip
Contact Information	Home or Cell Phone ( )	Work Phone ( )	Email	Country *(if not USA)*
Employment Information	Date of Hire (must be completed): / /	Name of Municipality: City of Framingham - Framingham Public Schools		

REQUIRED FOR ALL NEW ENROLLMENTS

For Agency Use Only	Does the employee participate in a public retirement system? ☐Yes ☐No	Check one: ☐Full-time ☐Part-time	Number of work hours/week:

REQUIRED

Select all that apply:

- ☐ New Enrollment
- ☐ Annual Enrollment
- ☐ Adding Dependent(s)
- ☐ Address Change
- ☐ Dropping Dependent(s)
- ☐ Name Change
- ☐ Decline GIC health insurance coverage

Qualifying Status Change Date of Event: ____ / ____ / _____

- ☐ Marriage
- ☐ Birth/Adoption
- ☐ Divorce/Legal Separation
- ☐ Change in Dependent Eligibility Status
- ☐ Gain of Other Coverage
- ☐ Involuntary Loss of Other Coverage
- ☐ Return from FMLA or Military Leave
- ☐ Death of spouse/dependent
- ☐ Spouse's Annual Enrollment
- ☐ Moved out of health plan's service area

HEALTH PLAN

Effective Date: / 01 /

Health Plan

- ☐ AllWays Health Partners Complete (HMO)
- ☐ Fallon Direct (HMO)
- ☐ Fallon Select (HMO)
- ☐ Harvard Pilgrim Independence (POS)
- ☐ Harvard Pilgrim Primary Choice (HMO)
- ☐ Health New England (HMO)
- ☐ Tufts Health Plan Navigator (POS)
- ☐ Tufts Health Plan Spirit (HMO-type)
- ☐ UniCare State Indemnity/Basic CIC: ☐Yes ☐No
- ☐ UniCare Community Choice (PPO-type)
- ☐ UniCare/PLUS (PPO-type)

Coverage Election: ☐Individual ☐Family

Cancel Health Insurance Coverage: ☐Yes ☐No

SPOUSE/DEPENDENT INFORMATION *(See instructions on back)*

For Changes Only	LAST NAME	FIRST NAME	MI	SSN (REQUIRED)	DATE OF BIRTH	SEX	RELATIONSHIP
☐Add ☐Drop					/ /	☐M ☐F	
☐Add ☐Drop					/ /	☐M ☐F	
☐Add ☐Drop					/ /	☐M ☐F	
☐Add ☐Drop					/ /	☐M ☐F	
☐Add ☐Drop					/ /	☐M ☐F	

FORMER SPOUSE INFORMATION – If Listed Above

Date of Divorce: / /

Are you remarried? ☐Yes ☐No	Date of your remarriage: / /	Has your former spouse remarried? ☐Yes ☐No	Date of former spouse's remarriage: / /
Address: Street	City	State	Zip

SIGNATURE REQUIRED

AUTHORIZATION – I have read the instructions on the reverse side of this form and authorize my employer, or direct my pension authority, to deduct from my payroll or pension check the amount required for the coverage I have selected. I understand that due to IRS regulations, my health insurance coverage elections are binding for the duration of the plan year and that I may only enroll in health insurance 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 coverage). I understand that the GIC must receive any required documentation for health insurance changes within 60 days of the event. **All divorces and remarriages must be reported to the Group Insurance Commission, failure to notify the GIC of a legal separation, divorce, or remarriage can result in financial liability to you.**

Signature of Applicant: _____ Date: _____

Signature of Authorized Official: _____ Date: _____

For GIC Use Only	Entered	Verified	Political Subdivision

(See over for Form-1MUN instructions)