SWAMPSCOTT PUBLIC SCHOOLS

Employee Information Change/Update Form

Name: _____ Effective Date of Change: _____

Type of Change: Name ☐ Address ☐ Phone Number ☐ Other ☐

*New Name: _____

*New Address: _____
(Street, City, State, Zip)

New Phone Number: _____

Other Change: _____

Signature Employee _____Date: _____

- **For name changes, the Town of Swampscott will need an updated Social Security card showing your new name .**
- **Please fill out page 2 to notify DESE of a name change. Follow the directions at the bottom of the DESE form when submitting.**
- **If you are currently enrolled in health insurance, please fill out page 3 of this form. The form will be turned into Town Hall to either Nancy Lord or Lynn Lavoie.**

Please Submit Form to Data Specialist/Superintendent's Office

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Office Use Only

Data Specialist Entered into Aspen on:_____by _____
(Initials)

Payroll Specialist entered into Munis on:_____by _____
(Initials)

IT Department Changes name/create alias on: _____by _____
(Initials)

This form will be filed in employee's personnel file.

Massachusetts Department of Elementary and Secondary Education

Office of Educator Licensure
75 Pleasant Street, Malden, Massachusetts 02148-4906
Telephone: (781) 338-6600
TTY: N.E.T. Relay (800) 439-2370

Request for a Name Change

Please complete all areas of this form (type or print). Submit this form together with a copy of an official name change document as evidence (see options noted below), so that we may process your request in a timely manner. There is no fee for a name change.

- Please enclose/include valid evidence of name change (e.g. copy of Marriage License and/or Divorce Decree, Social Security Card, or Driver's License).
  - Requests to change a name to a hyphenated name, for example: Connolly-Jones, must include valid evidence of this change (e.g. Social Security Card with hyphenated name as your valid evidence)
  - Requests to change middle and last name, for example using your maiden name as your middle name, must include valid evidence of this change (e.g. middle name on Social Security Card is your maiden/prior last name).

Current Last Name | Previous Last Name | First Name | MI

Street Address and Apartment Number (if any)

City | State | Zip Code

Email Address

Date of Birth (Month/Day/Year) | Social Security # | MEPID# or MA License #

Please print out this form and sign below.

Signature (Current Name) | Date

- The signed and dated *Request for a Name Change* form and supporting documentation can be:
  - **Uploaded directly into your ELAR account (fastest method)**.
    - Login to ELAR at www.mass.gov/ese/licensure
    - On the **Welcome to ELAR** screen, click on the **Check license status and history, make a payment** link
    - On the **Inquiry – Activity Summary** page, scroll towards the bottom and click on the **Upload Documents** button and follow prompts – click on Upload Help for any needed additional guidance.
      Please note: When choosing the Document Type, please select: **Proof of Name Change**
  - **Or, mailed to:** Massachusetts Department of Elementary and Secondary Education
    Office of Educator Licensure
    75 Pleasant Street
    Malden, MA 02148-4906

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 /0291
	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: Town of Swampscott		

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

- ☐ Fallon Direct (HMO)
- ☐ Fallon Select (HMO) *(Closed to New Members)*
- ☐ Harvard Pilgrim Independence (POS) *(Closed to New Members)*
- ☐ Harvard Pilgrim Primary Choice (HMO)
- ☐ Health New England (HMO)
- ☐ NHP Prime–Neighborhood Health Plan (HMO)
- ☐ Tufts Health Plan Navigator (POS) *(Closed to New Members)*
- ☐ 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.

Signature of Applicant: _____ Date: _____

Signature of Authorized Official: _____ Date: _____

For GIC Use Only	Entered	Verified	Political Subdivision

(See over for Form-1MUN instructions)

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

For an overview of your GIC benefit options, see your GIC Benefit Decision Guide mass.gov/gic/bdgs.

Deadlines and Required Documentation

- **Required Documentation:** To add a spouse or dependent to coverage, documentation is required. Refer to dependent information section below for details.
- **New Hire:** Completed paperwork and required documentation must be received by your GIC Coordinator no later than your 10th calendar day of regular, benefit eligible employment. If you miss the deadline, you must wait until the next Annual Enrollment period to enroll in GIC health insurance benefits.
- **Annual Enrollment:** Completed paperwork and required documentation must be received by your GIC Coordinator by the end of the Annual Enrollment period.
- **Qualifying Status Change for Health Insurance:** Municipal employees and retirees who have a qualified status change during the year can enroll in GIC health insurance or change from individual to family or family to individual coverage with proof of the family status change. Documentation of the event and the completed form must be received at the GIC within 60 days of the qualifying event. Forms received after 60 days are returned and you may re-apply during Annual Enrollment.
- **Return from FMLA or Military Leave:** If you voluntarily canceled GIC health insurance coverage at the beginning of your FMLA or military leave of absence, you can re-enroll in GIC health insurance coverage upon your return from leave. The enrollment form must be received at the GIC within 60 days of the return to work. Forms received after 60 days are returned and you may re-apply during Annual Enrollment.

Work Hours and Eligibility

Active municipal employees must work at least 18.75 hours in a 37.5-hour workweek or 20 hours in a 40-hour workweek and must contribute to your employer's public sector retirement system. For GIC purposes, OBRA is not such a retirement system. For additional eligibility details, refer to the GIC's Regulations: mass.gov/gic/regulations.

Dependent Information and Required Documentation

In order to enroll your eligible spouse, former spouse and/or dependents in GIC health insurance, you must enter their information in the spouse/dependent box and provide a copy of a marriage certificate, birth certificate or hospital announcement letter (newborns only), separation agreement, divorce decree, certificate of appointment as legal guardian, etc., for each person you list as a dependent. If covering a former spouse, also complete the former spouse information section. Failure to provide required documentation with this enrollment/change form will result in your spouse/dependent not being covered. If you are deleting a spouse or dependent under age 19, you must do so during Annual Enrollment or within 60 days of a qualifying event. Under federal health care reform, Social Security Numbers must be provided for each spouse/dependent to be covered under the health plan. For a newborn only, the Social Security Number can be provided at a later date. Please indicate the exact date of birth for each dependent. To cover a dependent age 19 to 26, you must also provide a completed Dependent Age 19 to 26 Enrollment and Change Form.

Form and Documentation Submission

Incomplete forms and insufficient required documentation may result in no coverage or a delayed effective date.

Active Employees: Return completed form and documentation to your GIC Coordinator.

(See over for Form-1MUN)