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)

Commonwealth of Massachusetts
Group Insurance Commission
Your Benefits Connection

DEPENDENT AGE 19 TO 26 ENROLLMENT/CHANGE FORM – FEDERAL HEALTH CARE REFORM (ACA)

Use this form to enroll your dependent age 19 to 26 for the first time or to report your dependent's age 19 to 26 status change. Upon receipt of a complete application, the GIC will determine coverage eligibility and effective date. For new insureds, coverage for the dependent age 19 to 26 will begin on the new insured's effective date. Dependents of existing GIC enrollees who are already over age 19 must have a qualifying event to enroll during the year or may apply during the GIC's Annual Enrollment. Incomplete applications will be returned. PLEASE USE ONE FORM FOR EACH DEPENDENT AGE 19 TO 26.

I am applying for coverage or reporting a status change for my dependent age 19 to 26. The GIC may require proof of relationship for the dependent you plan to cover and will contact you for any documents, if necessary.

Name of Insured _____ Social Security # ____/____/____

_____ Telephone #_____

Address

_____

City State Zip

PLEASE COMPLETE ONLY ONE SECTION BELOW
SECTION A – ENROLL YOUR DEPENDENT
SECTION B – CHANGE DEPENDENT STATUS

A) ENROLLMENT DEPENDENT AGE 19 TO 26 Use this section to enroll your dependent

Name of Dependent Age 19 - 26_____ Social Security #____/____/____

_____ Dependent's Date of Birth ____/___/____

Address

_____ Relationship to Insured _____

City State Zip

_____Check here if your dependent is a full-time student attending an accredited institution **outside your health plan's service area and provide school name and address below:** (Check with your health plan for benefits available to full-time students that are attending school outside the service area.)

Name of School _____ School Address _____

(That is outside health plan's service area)

_____

You must contact the GIC when your dependent is no longer a full-time student to continue coverage to age 26.

B) CHANGE OF DEPENDENT'S AGE 19 TO 26 STATUS Use this section to report dependent address and full-time student status changes

Name of Dependent Age 19 - 26_____ Social Security #____/____/____

_____ Dependent's Date of Birth ____/___/____

Address

_____ Relationship to Insured _____

City State Zip

_____Dependent Address Change New Address: _____

_____

_____Dependent is no longer a full-time student as of _____.

(Date)

SIGNATURE REQUIRED Please sign and date below

I understand that if my dependent is not a full-time student he/she must reside in my health plan's service area. If you are not sure, the GIC health plan service areas are listed in the GIC *Benefit Decision Guide* (available on our website, www.mass.gov/gic) or you may contact your health plan directly. If your dependent does not live in your health plan's service area and is not a full-time student, you must change health plans. The UniCare Indemnity Plan Basic is the only nationwide plan. ***Under the pains and penalties of perjury, I attest that all statements I have made on this form are true. I understand that if I misrepresent or provide false or incomplete information on this form my GIC coverage may be terminated (possibly retroactively), in addition to other legal remedies and financial consequences, at the GIC's discretion.***

Signature of Insured _____ **Date** _____

Return to: Group Insurance Commission, PO Box 8747, Boston, MA 02114

GIC USE ONLY APPROVED _____Effective Date _____ Expiration Date _____ DENIED _____

Revised 3/17