

RETIREE & SURVIVOR ENROLLMENT/CHANGE (FORM-RS)



Health Insurance

REQUIRED INFORMATION							
REQUIRED	Insured Information	GIC-ID (usually Soc. Sec. #) - -		Sex <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth / /	Dept. ID # or Agency/Division # /	
		Name – Last		First		MI	
	Address	Street			City	State	Zip
	Contact Information	Preferred Phone ()	Preferred Email			Country (if not USA)	
Claim Number	Insured's Medicare Claim #			Spouse's Medicare Claim #			

Retirement Information	Name of State Agency or Municipality retired from	Do you receive a monthly pension from a public retirement system? Yes No	Date of Retirement / /
Survivor Information	Name of Deceased Employee or Retiree	Deceased Employee's/Retiree's Soc. Sec. # - -	Have you remarried? <input type="checkbox"/> Yes Date of remarriage ___/___/___ <input type="checkbox"/> No

REQUIRED	Select all that apply:	<input type="checkbox"/> Dropping Dependent(s) <input type="checkbox"/> Name Change <input type="checkbox"/> Decline all GIC coverage <input type="checkbox"/> Cancel GIC health insurance during Annual Enrollment or during a qualifying event	Qualifying Event (Date of Event: ___ / ___ / ___) <input type="checkbox"/> Marriage <input type="checkbox"/> Birth/Adoption <input type="checkbox"/> Divorce/Legal Separation <input type="checkbox"/> Change in Dependent Eligibility Status	<input type="checkbox"/> Gain of Other Coverage <input type="checkbox"/> Involuntary Loss of Other Coverage <input type="checkbox"/> Death of spouse/dependent <input type="checkbox"/> Spouse's Annual Enrollment <input type="checkbox"/> Moved out of health plan's service area
	<input type="checkbox"/> New Enrollment (New Eligibility) <input type="checkbox"/> Adding Dependent(s) <input type="checkbox"/> Address Change <input type="checkbox"/> Annual Enrollment			

MEDICARE PLAN – Select one if you and/or your spouse/covered dependents are enrolled in Medicare.			Effective Date: / 01/
<input type="checkbox"/> Tufts Medicare Preferred (HMO) <input type="checkbox"/> Harvard Pilgrim Medicare Enhance (Indemnity) <input type="checkbox"/> Health New England Medicare Supplement Plus (Indemnity)	<input type="checkbox"/> Tufts Medicare Complement (Indemnity) <input type="checkbox"/> UniCare State Indemnity Medicare Extension with CIC (comprehensive) <input type="checkbox"/> UniCare State Indemnity Medicare Extension without CIC	Medicare Coverage Election <input type="checkbox"/> Individual <input type="checkbox"/> Individual and spouse <input type="checkbox"/> Family	Check all that apply: <input type="checkbox"/> Individual on Medicare <input type="checkbox"/> Spouse on Medicare <input type="checkbox"/> Dependent(s) on Medicare

NON-MEDICARE PLAN – Select one if you and/or your spouse/covered dependents are not enrolled in Medicare.				Non-Medicare Coverage Election
<input type="checkbox"/> AllWays Health Partners Complete (HMO) <input type="checkbox"/> Harvard Pilgrim Independence (POS) <input type="checkbox"/> Harvard Pilgrim Primary Choice (HMO)	<input type="checkbox"/> Health New England (HMO) <input type="checkbox"/> Tufts Health Plan Navigator (POS) <input type="checkbox"/> Tufts Health Plan Spirit (HMO-type)	<input type="checkbox"/> UniCare Community Choice (PPO-type) <input type="checkbox"/> UniCare/PLUS (PPO-type) <input type="checkbox"/> UniCare State Indemnity with CIC (comprehensive) <input type="checkbox"/> UniCare State Indemnity without CIC	<input type="checkbox"/> Individual <input type="checkbox"/> Family	

SPOUSE/DEPENDENT INFORMATION (See instructions on back)							
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	

FORMER SPOUSE INFORMATION – If Listed Above				Date of Divorce: / /
Are you remarried? <input type="checkbox"/> Yes <input type="checkbox"/> No	Date of your remarriage: / /	Has your former spouse remarried? <input type="checkbox"/> Yes <input type="checkbox"/> 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 direct my pension authority to deduct from my pension check the amount required for the coverage I have selected. I understand that 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 other coverage). I understand that the GIC must receive any required documentation within 60 days of the event. You must notify the GIC of a legal separation, divorce or remarriage of you or your former spouse; coverage for a former spouse ends upon remarriage. Failure to notify the GIC can result in financial liability to you.	
	Signature of Applicant: _____	Date: _____
	Signature of Authorized Official: _____	Date: _____

GIC RETIREE/SURVIVOR ENROLLMENT AND CHANGE FORM (FORM-RS) INSTRUCTIONS

Use this Form-RS to make GIC health plan changes for a qualifying status change, at Annual Enrollment, and for enrolling in GIC health insurance for the first time at retirement.

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

Deadlines and Required Documentation

- **Required documentation:** To add a spouse or dependent to coverage, documentation is required. Do not send original documents because they will not be returned. Visit our website for the Required Documentation list: mass.gov/info-details/gic-forms.
- If you and/or your spouse is **Medicare eligible** and **not already enrolled in GIC Medicare** coverage, the following documentation is needed:
 - Be sure to indicate you and/or your spouse's Medicare Claim number on the front of this form.
- If you and/or your spouse are over age 65 and **not eligible for Medicare** and have not already provided the following documentation to the GIC, it must accompany this form:
 - Social Security Denial letter stating that you and/or your spouse are not eligible for Medicare Part A for free.
- **Annual Enrollment:** Completed paperwork and required documentation must be received by the GIC (retirees and survivors) by the end of the Annual Enrollment period.
- **Qualifying Status Change:** Retirees and survivors with a qualifying status change must submit completed forms with proof of the qualifying status change (e.g., marriage or divorce) to the GIC within 60 days of the qualifying event.

Enrolling in health insurance for the first time: Use this form in addition to Form-1A to enroll at retirement in GIC health insurance for the first time. You must send with this form a copy of the letter from your retirement board approving your retirement. State retirees please note that your health insurance election includes basic life insurance.

Retiree and Spouse Coverage if Under and Over Age 65

If you (the retiree), your spouse or other covered dependent is younger than age 65, the person or people under age 65 will continue to be covered under a Non-Medicare plan until you and/or he/she becomes eligible for Medicare. Be sure to choose "individual" Non-Medicare coverage if only covering one Non-Medicare family member; select "family" Non-Medicare coverage if covering two or more Non-Medicare family members.

If enrolling in one of GIC's Medicare Plans, you will be automatically enrolled in the GIC's SilverScript Medicare Part D prescription drug plan. After your enrollment is processed by the GIC, you will receive a mailing from SilverScript with information about the plan and advising you that you have the choice to opt out of the prescription drug plan.

IMPORTANT: The opt-out letter is required by Medicare, but we do not recommend that you do so because **if you opt out of SilverScript, you will lose your GIC medical, prescription drug and behavioral health coverage. If you enroll in another non-GIC Medicare Part D plan anytime throughout the year, you will lose your GIC medical, prescription drug and behavioral health coverage.**

Tufts Medicare Preferred: Only if changing from this plan to another GIC Medicare option, you must also complete and send to the GIC a Medicare Advantage Plan/Disenrollment form.

Form and Document Submission

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

ONLINE: Visit bit.ly/MyGICLinkOnlineForms to request and submit your enrollment form(s).

MAIL: Return completed form and documentation to:

Group Insurance Commission
PO Box 556, Randolph, MA 02368.