# GIC INITIAL MUNICIPAL EMPLOYEE ENROLLMENT FORM (FORM-IME) Health Insurance

REQUIRED

## INSURED INFORMATION

| | | | | |
|---|---|---|---|---|
| **Insured Information** | GIC-ID (usually Soc. Sec. #) – – | Sex ☐ M ☐ F | Date of Birth / / | Dept. ID # or Agency/Division # / |
| | 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: | | |

## 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 one:
☐ New Enrollment ☐ Decline GIC health insurance coverage ☐ Cancel Coverage

☐ COBRA Enrollee
COBRA Expiration Date / /

## HEALTH PLAN

Effective Date: / 01 /

**Health Plan**

- ☐ Fallon Direct (HMO)
- ☐ Fallon Select (HMO)
- ☐ 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)
- ☐ 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

## SPOUSE/DEPENDENT INFORMATION

| | LAST NAME | FIRST NAME | MI | SSN (REQUIRED) | DATE OF BIRTH | SEX | RELATIONSHIP |
|---|---|---|---|---|---|---|---|
| ☐ Add | | | | | / / | ☐ M ☐ F | |
| ☐ Add | | | | | / / | ☐ M ☐ F | |
| ☐ Add | | | | | / / | ☐ M ☐ F | |
| ☐ Add | | | | | / / | ☐ M ☐ F | |
| ☐ Add | | | | | / / | ☐ 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 |
|---|---|---|---|