GIC INITIAL MUNICIPAL RETIREE/SURVIVOR ENROLLMENT FORM (FORM-IMRS)

Commonwealth of Massachusetts
Group Insurance Commission

INSURED INFORMATION

REQUIRED

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 Phone ( )	Cell Phone ( )	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? ☐Yes Date of remarriage___/___ /_____ ☐No

REQUIRED – Select one:
☐ New Enrollment (New Eligibility) ☐ Decline all GIC Coverage ☐ Cancel Coverage

MEDICARE PLAN – Select one if you and/or your spouse/covered dependents are enrolled in Medicare.

Effective Date: / 01 /

☐ Fallon Senior Plan (HMO) - separate application required
☐ Harvard Pilgrim Medicare Enhance (Indemnity)
☐ Health New England MedPlus (HMO)
☐ Tufts Medicare Complement (HMO)
☐ Tufts Medicare Preferred (HMO)
☐ UniCare State Indemnity Medicare Extension
CIC: ☐Yes ☐No
Medicare Part D Opt-In form required

Medicare Coverage Election
☐ Individual
☐ Individual and spouse
☐ Family

Check all that apply:
☐ Individual on Medicare
☐ Spouse on Medicare
☐ Dependent(s) on Medicare

NON-MEDICARE PLAN – Select one if you and/or your spouse/covered dependents are not enrolled in Medicare.

☐ 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)

Non-Medicare 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 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.

Signature of Applicant: _____ Date: _____

Signature of Authorized Official: _____ Date: _____

For GIC Use Only	Entered	Verified	Political Subdivision