



Commonwealth of Massachusetts
Group Insurance Commission

P.O. Box 8747 • BOSTON, MA 02114-8747
(617) 727-2310 www.mass.gov/gic

INSURANCE DATA FORM (IDF)

PLEASE PRINT CLEARLY

This form is required for new enrollments in any Group Insurance Commission family health plan and for any changes in spouse or dependents. Complete it and any other health plan forms provided by your Group Insurance Coordinator and return them to the Coordinator. If you are a retiree, please return the form to the GIC. Please PRINT clearly. Incomplete forms will be returned.

CHECK ONE: [ ] NEW MEMBER [ ] ADDITION [ ] DELETION [ ] CORRECTION

Important: You are required to provide a copy of a marriage certificate, birth certificate, separation agreement, divorce decree, certificate of appointment as legal guardian, etc., for each person you list as a dependent. Failure to provide this documentation will result in your spouse/dependent not being covered. If you are deleting a spouse or dependent under age 19, you must provide proof of other coverage.

INSURED INFORMATION

1) Social Security Number \_\_\_\_\_ 2) Date of Birth \_\_\_\_\_ 3) Sex [ ] M [ ] F
4) Name \_\_\_\_\_ Last First Middle
5) Address \_\_\_\_\_ Street
City State Zip Code
6) Are you enrolled in Medicare? [ ] Yes [ ] No If yes, Medicare claim # \_\_\_\_\_
7) Health Plan (Check one) [ ] Fallon Direct [ ] Health New England [ ] UniCare State Indemnity/Basic [ ] Medicare Plan
[ ] Fallon Select [ ] Navigator by Tufts Health Plan [ ] UniCare/Community Choice Fill in name of Medicare
[ ] Harvard Pilgrim Independence [ ] NHP Care - Neighborhood Health Plan [ ] UniCare/PLUS Plan: \_\_\_\_\_

SPOUSE/DEPENDENT INFORMATION

List below all family members, including your spouse, who will be covered under your family plan. Married children are not eligible. Please provide all Social Security Numbers and exact dates of birth for each dependent. Attach separate sheet if additional space is required. Coverage for children ends at age 19; to continue their coverage you must complete and return to the GIC a Dependent Age 19 and Over Application for Coverage.

Last Name First Middle Relationship Date of Birth Sex Social Security Number
\_\_\_\_\_
\_\_\_\_\_
\_\_\_\_\_
\_\_\_\_\_

Reason for addition or deletion: \_\_\_\_\_ Effective date: \_\_\_\_\_

SPOUSE INFORMATION

Is your spouse employed? [ ] Yes [ ] No Name of employer \_\_\_\_\_ Address of employer \_\_\_\_\_
Is your spouse covered under his or her employer's group health insurance plan? [ ] Yes [ ] No Name of insurance company \_\_\_\_\_
Policy/Certificate Number \_\_\_\_\_ Address of insurance company \_\_\_\_\_
Are you and/or your children covered under your spouse's group health insurance plan? You: [ ] Yes [ ] No Children: [ ] Yes [ ] No
Is your spouse enrolled in Medicare? [ ] Yes [ ] No If yes, Medicare claim number \_\_\_\_\_

FORMER SPOUSE

Name \_\_\_\_\_ Social Security Number \_\_\_\_\_ Date of Birth \_\_\_\_\_ Date of Divorce \_\_\_\_\_
Last First Middle
Address \_\_\_\_\_ Street City State Zip Code
Is your former spouse employed? [ ] Yes [ ] No Name of employer \_\_\_\_\_
Is your former spouse covered under his or her employer's group health insurance plan? [ ] Yes [ ] No

IMPORTANT: YOU MUST SIGN BELOW

Signed under the pains and penalties of perjury, I certify that the information I have provided is, to the best of my knowledge, complete and accurate.

Signature \_\_\_\_\_ Date \_\_\_\_\_

ACTIVE EMPLOYEES: RETURN COMPLETED FORM TO YOUR GIC COORDINATOR. RETIREES: RETURN COMPLETED FORM TO THE GIC Form IDF 3/08 10,000

FOR GIC COORDINATOR USE ONLY Dept. ID # or Agency/Division # UMS/0149
Name of GIC Coordinator Anna Pitocchelli Agency Telephone Number 6172877042
Agency Name UMass President's Office
Agency Address 225 Franklin Street; Boston, MA

FOR GIC USE ONLY
Entered \_\_\_\_\_
Verified \_\_\_\_\_
Date \_\_\_\_\_