



This form is required for new enrollments in any Group Insurance Commission family health plan and for any changes in spouse or dependents. Return the form to your GIC 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 [] Fallon Direct (HMO) [] Health New England (HMO) [] UniCare State Indemnity/Basic [] Medicare Plan
[] Fallon Select (HMO) [] NHP Care-Neighborhood Health Plan (HMO) [] UniCare/Community Choice (PPO-type) Fill in name of Medicare Plan
[] Harvard Pilgrim Independence (PPO) [] Tufts Health Plan Navigator (PPO) [] UniCare/PLUS (PPO-type)
[] Harvard Pilgrim Primary Choice (HMO) [] Tufts Health Plan Spirit (HMO-type)

SPOUSE/DEPENDENT INFORMATION

List below all family members, including your spouse or former spouse (if eligible), who will be covered under your family plan. Please provide all Social Security Numbers (required under Federal Law Section 111) 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, complete and return to the GIC a Dependent Ages 19 to 26 Enrollment Application.

Table with 7 columns: Last Name, First, Middle, Relationship, Date of Birth, Sex, Social Security Number (required). Multiple rows for listing family members.

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 INFORMATION

Name Last First Middle Social Security Number - - - Date of Birth Date of Divorce
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 3/11

FOR GIC COORDINATOR USE ONLY Dept. ID # or Agency/Division # UMS/0149
Name of GIC Coordinator Anna Pitocchelli Agency Telephone Number 774-455-7568
Agency Name University of Massachusetts President's Office
Agency Address 333 South Street; Shrewsbury, MA 01545

FOR GIC USE ONLY
Entered
Verified
Date