



01 Insured's GIC-ID (usually Soc. Sec. #) Sex: Male Female Date of Birth Dept. ID # or Agency/Division # Name - Last First MI Address This is a new address City State Zip Code Date Entered Service Bargaining Unit/Union Name HR/CMS or UMASS Employee ID #: Home Phone Work Phone

02 LIFE, HEALTH AND LTD COVERAGE Effective Date: / 01 /

New Enrollment Change Basic Life Only Long Term Disability (LTD) Basic Life and Health Annual Salary: \$ Salary Effective Date: / / Cancel Coverage Long Term Disability (LTD) Health Insurance Optional Life Insurance

Health Plan Fallon Direct (HMO) Fallon Select (HMO) Harvard Pilgrim Independence (PPO) Harvard Pilgrim Primary Choice (HMO) Health New England (HMO) NHP Care - Neighborhood Health Plan (HMO) Tufts Health Plan Navigator (PPO) Tufts Health Plan Spirit (HMO-type) UniCare State Indemnity/Basic CIC: Yes No UniCare/Community Choice (PPO-type) UniCare/PLUS (PPO-type) Individual Family

Optional Life Please Check One: Automatic Increase Non Automatic Increase Amount \$: Automatic Increase - Family Status Change Non Automatic Increase - Family Status Change Amount \$: Smoker Non-Smoker

03 Name Change Previous Name New Name

LEAVE OF ABSENCE FOR GIC USE ONLY: Effective Date: / 01 /

04 Leave Is: With Pay Without Pay Leave Type: Educational Maternity Military Caregiver FMLA Personal Reason Personal Illness Sabbatical FMLA Military Exigency Family (for dep < age 3) Other Industrial accident Suspension Military

05 Return to Payroll Deduction: First Day Back on Payroll FOR GIC USE ONLY: Effective Date: / 01 /

INSURED CHANGES

06 Retirement Date Retired ORP (Higher Ed Only) Fund Name: 07 Transfer to another Agency Name of Agency Transferred to Effective Date 08 Transfer from another Agency Previous Agency Effective Date 09 Termination Coverage (if elected) Termination Reason Termination Date 39-Week Layoff Coverage Deferred Retiree COBRA Conversion

SIGNATURE REQUIRED Deduction Authorization: I 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. Long Term Disability Insurance (LTD): I understand that by not applying to be insured for Long Term Disability (LTD) insurance when first eligible, I may not apply for LTD insurance until I have provided satisfactory medical evidence of insurability. Health Insurance: I understand that once I choose a health plan, I cannot change plans until the next annual enrollment, even if my doctor or hospital leaves the plan. Optional Life Insurance: I understand that by not applying to be insured for Optional Life Insurance when first eligible, I may not apply for or increase my Optional Life Insurance until I have provided satisfactory medical evidence of insurability or I have a qualified family status change. At Retirement: I hereby certify that I have filed an application for retirement and desire to continue my present coverage as a retiree. I also understand that if I am Medicare eligible, I am required to join one of the Group Insurance Commission's Medicare supplemental health plans to continue health coverage. Survivors: I am a surviving spouse and certify that I have not remarried and understand that if I do remarry I am no longer eligible for GIC coverage. Termination: I understand that by electing to continue coverage under COBRA or Conversion, I must complete and return the corresponding application in order for this coverage to go into effect. If you are applying for Health Insurance, be sure to file a Form IDF to list family members.

FOR GIC USE ONLY: Entered Verified Political Subdivision