

GIC RETIREE DENTAL ENROLLMENT/CHANGE FORM (FORM-RD)



REQUIRED INFORMATION					
REQUIRED Insured Information	GIC-ID (usually Soc. Sec. #) - -		Sex <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth / /	Dept. ID # or Agency/Division # /
	Name – Last			First	MI
REQUIRED Address	Street		City		State Zip
REQUIRED Contact Information	Home Phone ()	Cell Phone ()	Email		Country (if not USA)

Retirement Information	Name of State Agency or Municipality retired from	Do you receive a monthly pension from a public retirement system? <input type="checkbox"/> Yes <input type="checkbox"/> No	Date of Retirement / /
Survivor Information	Name of Deceased Employee or Retiree	Deceased Employee's/Retiree's Soc. Sec. # - -	Have you remarried? <input type="checkbox"/> Yes Date of remarriage ___/___/___ <input type="checkbox"/> No

REQUIRED	Select all that apply: <input type="checkbox"/> New Enrollment (New Eligibility) <input type="checkbox"/> Adding Dependent(s) <input type="checkbox"/> Dropping Dependent(s) <input type="checkbox"/> Address Change <input type="checkbox"/> Name Change <input type="checkbox"/> Annual Enrollment	Qualifying Status Change <input type="checkbox"/> Marriage <input type="checkbox"/> Birth/Adoption <input type="checkbox"/> Divorce/Legal Separation <input type="checkbox"/> Change in Dependent Eligibility Status	Date of Event: ___ / ___ / ___ <input type="checkbox"/> Gain of Other Coverage <input type="checkbox"/> Involuntary Loss of Other Coverage <input type="checkbox"/> Death of spouse/dependent <input type="checkbox"/> Spouse's Annual Enrollment
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RETIREE DENTAL		Effective Date: / 01 /
Coverage Election (check one) <input type="checkbox"/> Individual <input type="checkbox"/> Family		Cancel <input type="checkbox"/> GIC Retiree Dental Coverage
<ul style="list-style-type: none"> If you do not sign up for coverage within 60 days of retirement, you will not be able to enroll until the next annual enrollment period, unless you involuntarily lose dental coverage during the year or have a qualifying status change and apply within 60 days of the event. If you sign up for coverage and decide to cancel, you can never rejoin the plan. If you have family coverage and switch to an individual plan, your spouse and/or your eligible dependents can never rejoin the plan. 		

List below all family members, including your spouse, who will be covered under your dental plan. Please provide all Social Security Numbers and exact dates of birth for each dependent. Coverage for children ends at age 19; to continue their coverage, complete and return to the GIC a Dependent Age 19 to 26 Enrollment Form if not already submitted for GIC health insurance. The Group Insurance Commission requires you to provide a copy of a marriage certificate, legal separation, divorce decree, or certificate of appointment as legal guardian for each person you list as a dependent.

SPOUSE/DEPENDENT INFORMATION							
For Changes Only	LAST NAME	FIRST NAME	MI	SSN (REQUIRED)	DATE OF BIRTH	SEX	RELATIONSHIP
<input type="checkbox"/> Add <input type="checkbox"/> Drop					/ /	<input type="checkbox"/> M <input type="checkbox"/> F	
<input type="checkbox"/> Add <input type="checkbox"/> Drop					/ /	<input type="checkbox"/> M <input type="checkbox"/> F	
<input type="checkbox"/> Add <input type="checkbox"/> Drop					/ /	<input type="checkbox"/> M <input type="checkbox"/> F	
<input type="checkbox"/> Add <input type="checkbox"/> Drop					/ /	<input type="checkbox"/> M <input type="checkbox"/> F	
<input type="checkbox"/> Add <input type="checkbox"/> Drop					/ /	<input type="checkbox"/> M <input type="checkbox"/> F	

FORMER SPOUSE INFORMATION – If Listed Above				Date of Divorce: / /
Are you remarried? <input type="checkbox"/> Yes <input type="checkbox"/> No	Date of your remarriage: / /	Has your former spouse remarried? <input type="checkbox"/> Yes <input type="checkbox"/> No	Date of former spouse's remarriage: / /	
Address: Street		City	State	Zip

SIGNATURE REQUIRED	AUTHORIZATION – I have read the instructions above and direct my pension authority to deduct from my pension check the amount required for the coverage I have selected. I understand that my coverage elections are binding for the duration of the plan year and that I may only enroll in or change my coverage elections during the plan year if I experience a qualifying status change (examples include marriage, adoption/birth of a child, divorce, 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
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Return completed form and documentation to the Group Insurance Commission, P.O. Box 8747, Boston, MA 02114