



**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 \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Month Day Year 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  NHP Care-Neighborhood Health Plan  UniCare/Community Choice Fill in name of Medicare Plan  
 Harvard Pilgrim Independence  Tufts Health Plan Navigator  UniCare/PLUS  
 Harvard Pilgrim Primary Choice  Tufts Health Plan Spirit

**SPOUSE/DEPENDENT INFORMATION**

List below all family members, including your spouse or former spouse (if eligible), 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 INFORMATION**

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 3/10 10,000

FOR GIC COORDINATOR USE ONLY	FOR GIC USE ONLY
Dept. ID # or Agency/Division # _____	Entered _____
Name of GIC Coordinator _____ Agency Telephone Number _____	Verified _____
Agency Name _____	Date _____
Agency Address _____	