



Municipal Insurance Enrollment and Change Form (FORM -1MUN)

01

Insured's GIC-ID (usually Soc. Sec. #) — —	Sex: Male <input type="radio"/> Female <input type="radio"/>	Date of Birth / /	Dept. ID # or Agency/Division # 666/
Name - Last	First	MI	Check one: <input type="checkbox"/> Active Employee <input type="checkbox"/> Retiree <input type="checkbox"/> Survivor
Address <input type="checkbox"/> This is a new address	City	State	Zip Code
Date Entered Service / /	City or Town employed or retired from	Home Phone ()	Work Phone ()

02 **HEALTH COVERAGE** **Effective Date:** / 01 /

New Enrollment Change Cancel Coverage

Health (Select one of the health plans below and individual or family coverage)

Health Plan – Active Employees and Non-Medicare Retirees/Survivors

<input type="checkbox"/> Fallon Direct	<input type="checkbox"/> NHP Care – Neighborhood Health Plan (HMO app required)	<input type="checkbox"/> UniCare State Indemnity/Basic CIC: <input type="checkbox"/> Yes <input type="checkbox"/> No	Coverage <input type="checkbox"/> Individual <input type="checkbox"/> Family
<input type="checkbox"/> Fallon Select	<input type="checkbox"/> Tufts Health Plan Navigator	<input type="checkbox"/> UniCare/Community Choice	
<input type="checkbox"/> Harvard Pilgrim Independence	<input type="checkbox"/> Tufts Health Plan Spirit	<input type="checkbox"/> UniCare/PLUS	
<input type="checkbox"/> Harvard Pilgrim Primary Choice			
<input type="checkbox"/> Health New England			

03 **Name Change** Previous Name _____ New Name _____

INSURED CHANGES **FOR GIC USE ONLY:** **Effective Date:** / 01 /

06 **Retirement** Date Retired / /

07 **Transfer to another Agency/Municipality** Name of Agency/Municipality Transferred to _____ Effective Date / /

08 **Transfer from another Agency/Municipality** Previous Agency/Municipality _____ Effective Date / /

09 **Termination Coverage (if elected)** Termination Reason _____ Termination Date ____/____/____

39 -Week Layoff Coverage Deferred Retiree COBRA (must complete COBRA application) Conversion (contact carrier for application)

School Department Employees Only: Termination date ____/____/____ Premiums paid through ____/____/____

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.

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 • If you are enrolling in an HMO that requires a separate application, be sure to file an application with the Plan.

x _____ x _____
Signature of Applicant Date Signature of Authorized Official Date

FOR GIC USE ONLY: Entered Verified Political Subdivision