

DEPENDENT AGE 19 TO 26 ENROLLMENT/CHANGE FORM – FEDERAL HEALTH CARE REFORM (ACA)

Use this form to enroll your dependent age 19 to 26 for the first time or to report your dependent's age 19 to 26 status change. Upon receipt of a complete application, the GIC will determine coverage eligibility and effective date. For new insureds, coverage for the dependent age 19 to 26 will begin on the new insured's effective date. Dependents of existing GIC enrollees who are already over age 19 must have a qualifying event to enroll during the year or may apply during the GIC's Annual Enrollment. Incomplete applications will be returned. PLEASE USE ONE FORM FOR EACH DEPENDENT AGE 19 TO 26.

I am applying for coverage or reporting a status change for my dependent age 19 to 26. The GIC may require proof of relationship for the dependent you plan to cover and will contact you for any documents, if necessary.

Name of Insured _____ Social Security # ____/____/____

Telephone # _____
Address _____
City _____ State _____ Zip _____

PLEASE COMPLETE ONLY ONE SECTION BELOW
SECTION A – ENROLL YOUR DEPENDENT
SECTION B – CHANGE DEPENDENT STATUS

A) ENROLLMENT DEPENDENT AGE 19 TO 26 Use this section to enroll your dependent

Name of Dependent Age 19 - 26 _____ Social Security # ____/____/____

Dependent's Date of Birth ____/____/____
Address _____
City _____ State _____ Zip _____ Relationship to Insured _____

Check here if your dependent is a full-time student attending an accredited institution **outside your health plan's service area and provide school name and address below:** (Check with your health plan for benefits available to full-time students that are attending school outside the service area.)
Name of School _____ School Address _____
(That is outside health plan's service area)
You must contact the GIC when your dependent is no longer a full-time student to continue coverage to age 26.

B) CHANGE OF DEPENDENT'S AGE 19 TO 26 STATUS Use this section to report dependent address and full-time student status changes

Name of Dependent Age 19 - 26 _____ Social Security # ____/____/____

Dependent's Date of Birth ____/____/____
Address _____
City _____ State _____ Zip _____ Relationship to Insured _____

Dependent Address Change New Address: _____

Dependent is no longer a full-time student as of _____.
(Date)

SIGNATURE REQUIRED Please sign and date below

I understand that if my dependent is not a full-time student he/she must reside in my health plan's service area. If you are not sure, the GIC health plan service areas are listed in the GIC *Benefit Decision Guide* (available on our website, www.mass.gov/gic) or you may contact your health plan directly. If your dependent does not live in your health plan's service area and is not a full-time student, you must change health plans. The UniCare Indemnity Plan Basic is the only nationwide plan. **Under the pains and penalties of perjury, I attest that all statements I have made on this form are true. I understand that if I misrepresent or provide false or incomplete information on this form my GIC coverage may be terminated (possibly retroactively), in addition to other legal remedies and financial consequences, at the GIC's discretion.**

(Please complete form, print and sign form. Original signature required.)
Signature of Insured _____ Date _____

Return to: Group Insurance Commission, PO Box 8747, Boston, MA 02114

GIC USE ONLY APPROVED _____ Effective Date _____ Expiration Date _____ DENIED _____