



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 BASIC LIFE, HEALTH AND LTD COVERAGE Effective Date: / 01 / New Enrollment Change CANCEL COVERAGE Long Term Disability (LTD) Health Insurance Optional Life Insurance Basic Life Only Annual Salary: \$ Long Term Disability (LTD) Basic Life and Health (Select one of the Health Plans below) Salary Effective Date: / /

Health Plan Commonwealth Indemnity Plan CIC: Yes No Commonwealth Indemnity Plan PLUS Harvard Pilgrim POS Navigator by Tufts Health Plan Individual Commonwealth Indemnity Community Choice HMO: (write in the name of the HMO) Family

Optional Life Please Check One: Automatic Increase Indicate Multiple Factor (1-8): Multiple Factor 2-8 times is allowed only with Automatic increase. Changing from Non Automatic to Automatic requires a medical form. Non Automatic Increase Amount \$: No more than \$1000 less than annual salary rounded down to the nearest \$ 1,000 Please Check One: Smoker Non-Smoker Yes, I have been tobacco free for the past 12 months and choose the lower optional life insurance rates

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 (You MUST Check one of the following): Educational Family (for dep > age 3) Maternity Personal Illness Sabbatical FMLA Family (for dep < age 3) Industrial Accident Military Personal Reason Suspension Other * Industrial Accident (without pay), Maternity (without pay), and Personal Illness (without pay) leaves all require the employee to submit a Form 11 to the Group Insurance Commission with a letter from the agency head approving the leave of absence. Duration of Leave: Start Date End Date Last Day on Payroll

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

06 Retirement Date Retired 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 (must complete COBRA application) Conversion (contact carrier for application)

SIGNATURE REQUIRED 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. Optional Life Insurance I understand that by not applying to be insured for the maximum amount of Optional Life Insurance available to me when first eligible, I may not increase my Optional Life insurance until I have waited at least one year from the original effective date and satisfactorily pass a medical examination. 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, or intend to file, 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. 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 HPHC POS or an HMO, be sure to file an application with the Plan. X Signature of Authorized Official Date X Signature of Authorized Applicant Date

FOR GIC USE ONLY: Entered Verified Political Subdivision