International Special Enrollment Form for Health Care Coverage

Group Plans

This application is used only for circumstances where health care coverage is being requested for an individual after an employee's or dependent's initial eligibility period has passed. If the employee is enrolling in Group Plans for the first time, a *Group Plans Enrollment Form* **must** accompany this form for enrollment.

Special Enrollees

If an individual meets one of the following requirements, this person is a special enrollee:

- Loss of eligibility for other health care coverage; application for enrollment must be made within 60 days of the event.
- Acquisition of a dependent through marriage, birth, adoption or placement for adoption; application for enrollment must be made within 60 days of the event.

If approved, the medical coverage will become effective the day of the qualifying event.

GENERAL INFORMATION

Employer name: ______________________________ Employer number: ____________________

Employer city: ______________________________ State: ________ ZIP Code: ____________________

Employee first name: ______________________________ MI: ____ Last name: ______________________________

Social Security number: ______________________________

Employee address: ______________________________ City: ____________________ State: ____ ZIP Code: ________

Email: ______________________________ Home telephone: (______) ____________________

Coverage is being requested for (check all that apply):

☐ Self ☐ Spouse ☐ Dependent children

From the choices below, please indicate the reason coverage is being requested for you and/or your dependents:

☐ Loss of other health care coverage (indicate specific reason) Date of event: _____/_____/_____

☐ Company out of business ☐ Layoff ☐ Retirement ☐ End of COBRA eligibility ☐ Employer stopped contributions

☐ Death ☐ Divorce ☐ Termination of employment ☐ Other: ____________________

☐ Dependent addition (indicate specific addition) Date of event: _____/_____/_____

☐ Marriage ☐ Birth ☐ Adoption ☐ Placement for adoption

If adding a dependent please indicate if you would like to add life and/or dental coverage for special enrollee(s):

☐ Spouse Life ☐ Child Life ☐ Dental

Continued on other side

Employee name: ______________________________ Social Security number (last four digits): ____________

COVERAGE REQUESTED

	Check one
Health Legacy 200[3]	☐
Health Today	☐
Health Choice 500	☐
Health Choice 1000	☐
Health Choice 1500	☐
Health Choice 2000	☐
Health Choice 2500[1]	☐
Health Choice 3000[1]	☐
Health Choice 3000 80/20[1]	☐
Health Choice 5000[1]	☐
Health Choice 5000 80/20[1]	☐
Value Health 5000[1,2]	☐
Health Saver 1500	☐
Health Saver 2600[1]	☐
Health Saver 2800[1]	☐
Health Saver 3000[1]	☐
Health Saver 5000[1]	☐
Global Health 500	☐
Global Health 1000	☐
Global Health 2000	☐
Global Health 2000 Plus	☐

[1] This plan does not constitute "creditable coverage" for Massachusetts residents.
[2] This plan is not considered "creditable coverage" under Medicare Part D for active participants age 65 and older. Participants in this plan could incur late enrollment penalties from Medicare.
[3] This plan is open only to employers who currently have employees participating in the plan.

Note:
Please complete and submit both this form and the *Medicare-Coordinating Plans – Retiree Enrollment (Group Plans)* (included in form *8714 Group Plans Medicare-Coordinating Plans Packet*) if you are selecting a Medicare-coordinating plan. The coverage effective date depends on the date these forms are received.

IF YOUR DEPENDENT(S) ARE TO BE COVERED, PROVIDE THE FOLLOWING INFORMATION*

Last name	First name	MI	Social Security number	Date of birth	Relationship	Sex M/F

*Applicable to your spouse and any children to age 26.

COMPLETE SIGNATURE INFORMATION BELOW

I hereby request my employer to arrange for the issuance of the benefits to which I am now entitled, or to which I may become entitled under the terms of the group policy or policies issued to and/or administered by GSFR, and I authorize my employer to make the proper deductions, if any, from my earnings as my contribution toward the cost of this insurance.

Employee signature: ______________________________ Date: _____/_____/_____

Employer authorized representative: ______________________________ Date: _____/_____/_____

Copy this form as needed.