INTERNATIONAL EMPLOYEE ANNUAL CHANGE REQUEST
GROUP PLANS

Note: Complete and return this form to your employer to change your coverage option(s) to the plans listed below. Your employer will need to return this form to GSFR. The coverage available for your selection is contingent upon your employer's enrollment and participation in the plan.

EMPLOYEE INFORMATION (Please provide dependent information on the reverse side, if applicable.)

Employee first name: ____________ MI: ___ Last: ____________ Effective date: 1/1/2024

Employee mailing address: ____________

City: ____________ State: ______ ZIP code: ______

Country of destination: ____________ Airport code: ______

Social Security number (last four digits): ______ Email: ____________

Telephone: ____________ Classification: ____________ (e.g., ministerial, administrative)

Please provide dependent information on the reverse side, if applicable.

EMPLOYER INFORMATION

Employer name: ____________

Employee address: ____________

City: ____________ State: ______ ZIP code: ______

Employer number: ____________ Email: ____________

MEDICAL PLAN OPTIONS

Coverage option (please check): ☐ For myself ☐ For spouse ☐ For eligible children

Stateside coverage (select one): ____________

[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.

Overseas coverage (select one): ____________

[1]This plan does not constitute "creditable coverage" for Massachusetts residents.

DENTAL PLAN OPTIONS

Coverage option (please check): ☐ For myself ☐ For spouse ☐ For eligible children

Stateside coverage (select one): ____________

Overseas coverage (select one): ____________

VISION PLAN OPTIONS

Coverage option (please check): ☐ For myself ☐ For spouse ☐ For eligible children

Stateside coverage (select one): ____________

Continued on other side

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AUTHORIZED SIGNATURES

Employee signature: ______________________________ Date: ____________

Employer authorized representative signature: ______________________________ Date: ____________

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

PARTICIPANT & DEPENDENT* INFORMATION (ONLY LIST FAMILY MEMBERS TO BE COVERED)

An eligible spouse is a person of the opposite biological sex to whom you are legally married at the relevant time by civil or religious ceremony effective under the laws of the state in which the marriage was contracted.

An eligible dependent child is a person under age 26 (unless 26 and over and permanently incapacitated) that is dependent on you or your spouse for support or maintenance and includes the following:

- Biological child
- Stepchild
- Foster child
- Grandchild
- Child for whom you or your spouse is the legal guardian or managing conservator
- Child who you or your spouse must cover pursuant to a court or agency order or National Medical Support Notice under federal law
- Child 26 or over that is permanently incapacitated

Last name	First name	MI	Social Security Number	Birthdate	Relationship	Sex M/F	Medical Y/N	Dental Y/N	Dental ID Number†	Vision Y/N
			———	———	Self	—				

* Your spouse and children under age 26 are eligible for coverage.
† Cigna Dental Care DHMO only.

☐ I acknowledge that failure to adhere to the eligibility rules will result in the termination of coverage for the affected enrollee(s), and GSFR may require reimbursement for claims paid on behalf of ineligible enrollees.

WAIVER OF MEDICAL AND/OR DENTAL COVERAGE

For new Group Plans participants: If coverage is fully paid for by your employer, you must complete this section to waive (decline) medical and/or dental coverage for both you and your dependents under Group Plans.

This is to certify that I have been given the opportunity to apply for or continue medical and/or dental coverage provided to me and/or my dependents at no cost to me by my employer. **My employer has not provided or indicated that it will provide any financial or other incentive whose primary purpose is to cause me to waive coverage.** I understand that my dependents are not eligible for coverage if I waive coverage for myself.

I waive medical coverage for:

☐ Myself
☐ All eligible dependents
☐ Myself and all eligible dependents
☐ Only these dependents:

I waive dental coverage for:

☐ Myself
☐ All eligible dependents
☐ Myself and all eligible dependents
☐ Only these dependents:

I waive vision coverage for:

☐ Myself
☐ All eligible dependents
☐ Myself and all eligible dependents
☐ Only these dependents:

Name: ______________________________ Social Security number (last four digits): ____________

Name: ______________________________ Social Security number (last four digits): ____________

Name: ______________________________ Social Security number (last four digits): ____________

AUTHORIZED SIGNATURES

Employee signature: ______________________________ Date: ____________

Employer authorized representative signature: ______________________________ Date: ____________