INTERNATIONAL SPECIAL ENROLLMENT FORM
GROUP PLANS

This application is used only for circumstances where medical, dental, or vision 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, an International 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, 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: _____

Social Security number: _____

Mailing address: _____

City: _____ State: _____ ZIP code: _____

Email: _____ 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: _____

*If your reason coverage is being requested is not listed, please select "Other" and write in the reason.

☐ 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 term life, dental, and/or vision coverage for special enrollee(s):

☐ Spouse Term Life ☐ Child Term Life ☐ Dental ☐ Vision

NOTES

_____

_____

_____

_____

Continued on other side

Employee name: _____ Social Security number (last four digits): _____

COVERAGE REQUESTED

Medical Plan Options

For myself: ☐ Yes ☐ No For my spouse: ☐ Yes ☐ No For eligible children: ☐ Yes ☐ No

Stateside coverage (select one): _____

Overseas coverage (select one): _____

If your medical plan is not listed, please provide the name of the medical plan requested for enrollment:

_____

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

[2]This plan does not constitute "creditable coverage" for active members age 65 and older under Medicare Part D. Participants in this plan could incur late enrollment penalties from Medicare.

Dental Plan Options

For myself: ☐ Yes ☐ No For my spouse: ☐ Yes ☐ No For eligible children: ☐ Yes ☐ No

Stateside coverage (select one): _____

Global coverage (select one): _____

[†]Dental ID number required; please provide on page 2.

Vision Plan Options

For myself: ☐ Yes ☐ No For my spouse: ☐ Yes ☐ No For eligible children: ☐ Yes ☐ No

Stateside coverage (select one): _____

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

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

*Applicable to your spouse and any children under 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's Authorized Representative signature: _____ Date: _____

NOTE: If completed via DocuSign, no further action is necessary. DocuSign will forward this form to GSFR on your behalf.