

# MUNICIPAL RETIREE DENTAL ENROLLMENT/ CHANGE (FORM-MRD)



REQUIRED INFORMATION					
REQUIRED	Insured Information	GIC-ID (usually Soc. Sec. #) - -	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth / /	Dept. ID # or Agency/Division # /
		Name – Last		First	MI
REQUIRED	Address	Street		City	State Zip
		Contact Information	Preferred Phone ( )	Preferred Email	Country (if not USA)

Retirement Information	Name of Municipality retired from	Do you receive a monthly pension from a public retirement system? <input type="checkbox"/> Yes <input type="checkbox"/> No	Date of Retirement / /
Survivor Information	Name of Deceased Employee or Retiree	Deceased Employee's/Retiree's Soc. Sec. # - -	Have you remarried? <input type="checkbox"/> Yes Date of remarriage ___/___/___ <input type="checkbox"/> No

REQUIRED	<b>Select all that apply:</b> <input type="checkbox"/> New Enrollment (New Eligibility) <input type="checkbox"/> Adding Dependent(s) <input type="checkbox"/> Dropping Dependent(s) <input type="checkbox"/> Other Benefit Changes <input type="checkbox"/> Address Change <input type="checkbox"/> Annual Enrollment <input type="checkbox"/> Name Change	<b>Qualifying Event (Date of Event: ___/___/___)</b> <input type="checkbox"/> Marriage <input type="checkbox"/> Birth/Adoption <input type="checkbox"/> Divorce/Legal Separation <input type="checkbox"/> Change in Dependent Eligibility Status <input type="checkbox"/> Gain of Other Coverage <input type="checkbox"/> Involuntary Loss of Other Coverage <input type="checkbox"/> Death of spouse/dependent <input type="checkbox"/> Spouse's Annual Enrollment
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RETIREE DENTAL		Effective Date: / 01 /
Coverage Election (check one) <input type="checkbox"/> Individual <input type="checkbox"/> Family	Cancel <input type="checkbox"/> GIC Retiree Dental Coverage	
<ul style="list-style-type: none"> <li>• If you do not sign up for coverage within 60 days of retirement, you will not be able to enroll until the next annual enrollment period, unless you involuntarily lose dental coverage during the year or have a qualifying status change and apply within 60 days of the event.</li> <li>• If you sign up for coverage and decide to cancel, you can never rejoin the plan.</li> <li>• If you have family coverage and switch to an individual plan, your spouse and/or your eligible dependents can never rejoin the plan.</li> </ul>		

List below all family members, including your spouse, who will be covered under your dental plan. Please provide all Social Security Numbers and exact dates of birth for each dependent. Coverage for children ends at age 19; to continue their coverage, complete and return to the GIC a Dependent Age 19 to 26 Enrollment Form if not already submitted for GIC health insurance. The Group Insurance Commission requires you to provide a copy of a marriage certificate, legal separation, divorce decree, or certificate of appointment as legal guardian for each person you list as a dependent. Do not send original documents because they will not be returned.

SPOUSE/DEPENDENT INFORMATION							
For Changes Only	LAST NAME	FIRST NAME	MI	SSN (REQUIRED)	DATE OF BIRTH	SEX	RELATIONSHIP
<input type="checkbox"/> Add <input type="checkbox"/> Drop					/ /	<input type="checkbox"/> M <input type="checkbox"/> F	
<input type="checkbox"/> Add <input type="checkbox"/> Drop					/ /	<input type="checkbox"/> M <input type="checkbox"/> F	
<input type="checkbox"/> Add <input type="checkbox"/> Drop					/ /	<input type="checkbox"/> M <input type="checkbox"/> F	
<input type="checkbox"/> Add <input type="checkbox"/> Drop					/ /	<input type="checkbox"/> M <input type="checkbox"/> F	
<input type="checkbox"/> Add <input type="checkbox"/> Drop					/ /	<input type="checkbox"/> M <input type="checkbox"/> F	

FORMER SPOUSE INFORMATION – If Listed Above				Date of Divorce: / /
Are you remarried? <input type="checkbox"/> Yes <input type="checkbox"/> No	Date of your remarriage: / /	Has your former spouse remarried? <input type="checkbox"/> Yes <input type="checkbox"/> No	Date of former spouse's remarriage: / /	
Address: Street		City	State	Zip

SIGNATURE REQUIRED	<b>AUTHORIZATION</b> – I have read the instructions on this form and direct my pension authority to deduct from my pension check the amount required for the coverage I have selected. I understand that my coverage elections are binding for the duration of the plan year and that I may only enroll in or change my coverage elections during the plan year if I experience a qualifying status change (examples include marriage, adoption/birth of a child, death of a dependent, and involuntary loss of other coverage). I understand that the GIC must receive any required documentation within 60 days of the event. <b>You must notify the GIC of a legal separation, divorce or remarriage of you or your former spouse; coverage for a former spouse ends upon remarriage. Failure to notify the GIC can result in financial liability to you.</b>
	Signature of Applicant: _____ Date: _____ Signature of Authorized Official: _____ Date: _____

**666/0178 City of Melrose**

Diane Barrett  
 HR Coordinator  
 562 Main Street  
 Melrose, MA 02176  
 (781) 979-4145

**666/0014 Town of Ashland**

Susan Huwe  
 Benefits Coordinator  
 101 Main Street  
 Ashland, MA 01721  
 (508) 881-0100 x7926

**666/0023 Town of Bedford**

Colleen Doyle  
 Human Resources Manager  
 10 Mudge Way  
 Bedford, MA 01730  
 (781) 275-1111 x310

**666/0046 Town of Brookline**

Kayla Toleno  
 Benefits Administrator  
 333 Washington St.  
 Brookline, MA 02445  
 (617) 730-2117

**666/0133 Town of Holbrook**

Pamela Vayda  
 Human Resources Administrator  
 50 N. Franklin Street  
 Holbrook, MA 02343-1560  
 (781) 767-5567

**666/0168 Town of Marblehead**

Jeremy LeJeune  
 Benefits Coordinator  
 Mary Alley Municipal Building  
 7 Widger Road  
 Marblehead, MA 01945  
 (781) 631-1705

**666/0182 Town of Middleborough**

Susan Powers  
 Benefit Coordinator  
 20 Centre Street-3rd Floor  
 Middleborough, MA 02346  
 (508) 946-2420 x1127

**666/0187 Town of Millis**

Jennifer Scannell  
 Treasurer/Collector  
 900 Main Street  
 Millis, MA 02054  
 (508) 376-7091

**666/0210 Town of North Andover**

Kerry Meisinger  
 Human Resources Director  
 120 Main Street  
 North Andover, MA 01845  
 (978) 688-9526 x 40107

**666/0244 Town of Randolph**

Cilenia Bevis  
 Payroll/Benefits Clerk  
 Town Hall  
 41 South Main Street  
 Randolph, MA 02368  
 (781) 961-0911

**666/0291 Town of Swampscott**

Bonnie Lavoie  
 HR Generalist & Benefits Coordinator  
 Personnel Dept.  
 22 Monument Avenue  
 Swampscott, MA 01907  
 (781) 596-8850 x 1262

**666/0333 Town of Weston**

Leila Hewitt  
 HR Benefits Coordinator  
 11 Town House Road  
 Weston, MA 02493  
 (781) 786-5090

**666-0335 Town of Westwood**

Jennifer Kinnear  
 HR Administrator  
 580 High Street  
 Westwood, MA 02090  
 (781) 320-1072

**666/0503 Athol-Royalston Reg. School Dist.**

Angela Kitzmiller  
 Bookkeeper  
 P.O. Box 968  
 Athol, MA 01331  
 (978) 249-2400 x 2305

**666/0507 NE Metro Regional Voc. Tech. School**

Deanna Yannios  
 Accountant  
 100 Hemlock Road  
 Wakefield, MA 01880  
 (781) 246-0810 x1628

**Form and Document Submission**

Incomplete forms and insufficient required documentation may result in no coverage or a delayed effective date.

**ONLINE:** Visit [bit.ly/MyGICLinkOnlineForms](http://bit.ly/MyGICLinkOnlineForms) to request and submit your enrollment form(s).

**MAIL:** Return completed form and documentation to your municipal benefits office.

Group Insurance Commission  
 PO Box 556, Randolph, MA 02368