Commonwealth of Massachusetts
Group Insurance Commission
Your Benefits Connection

DEPENDENT AGE 19 TO 26 ENROLLMENT/CHANGE FORM – FEDERAL HEALTH CARE REFORM (ACA)

Use this form to enroll your dependent age 19 to 26 for the first time or to report your dependent's age 19 to 26 status change. Upon receipt of a complete application, the GIC will determine coverage eligibility and effective date. For new insureds, coverage for the dependent age 19 to 26 will begin on the new insured's effective date. Dependents of existing GIC enrollees who are already over age 19 must have a qualifying event to enroll during the year or may apply during the GIC's Annual Enrollment. Incomplete applications will be returned. PLEASE USE ONE FORM FOR EACH DEPENDENT AGE 19 TO 26.

I am applying for coverage or reporting a status change for my dependent age 19 to 26. The GIC may require proof of relationship for the dependent you plan to cover and will contact you for any documents, if necessary.

Name of Insured_____ Social Security # _____/_____/_____

_____ Telephone #_____

Address

_____ PLEASE COMPLETE ONLY ONE SECTION BELOW

City State Zip SECTION A – ENROLL YOUR DEPENDENT

SECTION B – CHANGE DEPENDENT STATUS

A) ENROLLMENT DEPENDENT AGE 19 TO 26 **Use this section to enroll your dependent**

Name of Dependent Age 19 - 26_____ Social Security #_____/_____/_____

_____ Dependent's Date of Birth ____/___/____

Address

_____ Relationship to Insured _____

City State Zip

_____Check here if your dependent is a full-time student attending an accredited institution **outside your health plan's service area and provide school name and address below:** (Check with your health plan for benefits available to full-time students that are attending school outside the service area.)

Name of School _____ School Address _____

(That is outside health plan's service area) _____

You must contact the GIC when your dependent is no longer a full-time student to continue coverage to age 26.

B) CHANGE OF DEPENDENT'S AGE 19 TO 26 STATUS **Use this section to report dependent address and full-time student status changes**

Name of Dependent Age 19 - 26_____ Social Security #_____/_____/_____

_____ Dependent's Date of Birth ____/___/____

Address

_____ Relationship to Insured _____

City State Zip

_____Dependent Address Change New Address: _____

_____

_____Dependent is no longer a full-time student as of _____.

(Date)

SIGNATURE REQUIRED **Please sign and date below**

Full-time student and non-student adult children age 19-26 may reside outside of your health plan's service area but will be subject to the plan's coverage rules. Be sure to review your plan's out of service area coverage and consider whether you should change to a plan providing greater geographical coverage for your dependent. ***Under the pains and penalties of perjury, I attest that all statements I have made on this form are true. I understand that if I misrepresent or provide false or incomplete information on this form my GIC coverage may be terminated (possibly retroactively), in addition to other legal remedies and financial consequences, at the GIC's discretion.***

Signature of Insured _____ Date _____

Return to: Group Insurance Commission, PO Box 8747, Boston, MA 02114

GIC USE ONLY APPROVED _____Effective Date _____ Expiration Date _____ DENIED _____