# *Choosing A Health Plan*

***How do I choose a health insurance plan?***

***There are several steps you should take before making your final decision.***

a. Make a list of the Doctors that you and your family use
b. Make a list of the hospitals that you would want to frequent if needed

Once you have made your list of providers, use the vendor websites to be sure that your choices of providers are in network. Check several different websites.

Also check to see what tier your chosen providers are in. They can be tiered differently by vendor and the copays will differ by tier.

***Once you have identified the providers that you want to use and the vendors that utilize those providers confirm the services that are offered. This may require a call to the customer service line for the vendors.***

Do you use a chiropractor? Not all vendors cover chiro benefits.
Do you have a child with special speech needs – coverage may vary by vendor.

***Things to remember***

- You receive the least costly option by using in network providers.
- A PPO allows you to use out of network providers with a greater out of pocket cost.
- An HMO will not reimburse for an out of network provider unless they have pre-approved using that provider.
- All HMO's require that you select a PCP.
- Some HMO's require that you get a referral before seeing a specialist.

***Now it is time to pick a PLAN!***

Premium cost vary greatly by plan, now is the time to look at the rate sheet. Determine the premium cost of the plan, the out of pocket expenses that you will incur and choose the plan that will meet you and your family's needs.

## ***NEED HELP***

You can call any of the vendor's customer service lines. Their phone numbers are located in the contact list tab.

Call the Insurance Department at City Hall. Our phone number is 787-6055. We are here to assist with specific questions or needs that you may have.

# ***WHAT DO I NEED TO DO?????***

*If I want Health Insurance Coverage though the City*

1. Complete Page 1 of the enrollment form if I want coverage for myself only
2. Complete Page 2 also, if I want to cover my eligible dependents
3. Sign and include a copy of the "Municipal Employee Acknowledge Form".
4. Include copies of a marriage certificate for my spouse and birth certificates for my children.
5. If my child is between 19 and 26, complete the Patient Protection and Affordable Care Act form
6. Include divorce decrees or court orders if required

*If I do not want Health Insurance through the City*

1. Complete the Health Insurance Disclosure Form that is included in this package.

*If I want Flexible Spending through the City*

1. Complete the enrollment form – REMEMBER Dependent Care is for Day Care Expenses

*If I want life insurance though the City*

Complete and sign the enrollment form

Return all Documents to:

Insurance Department
City Hall
36 Court Street
Springfield, Ma 01103

***Documents must be received within 2 weeks of the first day of your employment***

Office Hours

Monday – Thursday 8:15-4:00
Friday 9:00 - 4:00

For questions please call 787-6055.

# Required Documents for GIC Coverage for All New Enrollees For All GIC Health Plans

**If you are planning to cover yourself only:**

- There is no documentation needed other than the enrollment forms and Medicare information (if applicable)

**If you are planning to cover a current and/or former spouse (as determined by your divorce agreement), you will need the following:**

- Spousal Coverage – Copy of Certified Marriage Certificate

- Former Spouse- Following sections of divorce agreement are required:
  - Divorce Absolute Date
  - Signature Page
  - Health Insurance Language
  - Spouse's Last Known Address
- If the subscriber has remarried, then the former spouse will need to complete their own individual enrollment form. In addition, the former spouse will be billed separately and directly by the GIC. ( You must notify the Insurance Department if you remarry regardless if you plan on covering your new spouse).

**If you are planning to cover dependent children, you will need the following:**

- Dependent Child Coverage (New and Existing) – Copy of Certified (Long Form) Birth Certificate
- Student Coverage Over Age 19 – Complete a GIC Student Verification Form (Available at the open enrollment events, online at http://www.mass.gov/gic, and the Personnel office, Room 018 in City Hall). If your dependent is over age 19 and not enrolled full time in an accredited college, you may be subjected to imputed income. For additional details contact the GIC at 617-727-2310.
- Handicap Dependents – Complete a GIC Handicap dependent form (Available by contacting the GIC at 617-727-2310).
- Adoption – Copy of Adoption Placement Letter
  - Letter must be on Adoption Agency Letterhead and include the following:
  - Name of Adoptive Parents
  - Name of Adopted Child
  - Date Child Placed in the Home
- Grandchild – Copy of Court Guardianship Appointment
  - However, if grandchild is a dependent of a dependent under age 19, copy of grandchild's certified (Long Form) birth certificate

The Commonwealth of Massachusetts
Executive Office of Health and Human Services
Division of Health Care Finance and Policy

# Employee Health Insurance Responsibility Disclosure Form

**You are completing this form because you have declined to participate in your employer sponsored health insurance plan and/or have declined to participate in the employer's "Section 125 Cafeteria Plan" pre-tax purchasing arrangement. A Section 125 Plan is not health insurance; it is a way to purchase health insurance on a pre-tax basis. For information about affordable health insurance options, visit the Commonwealth Connector at < www.mahealthconnector.org >.**

## Employer

*Employers: please complete this section. See reverse side for instructions.*

**Employer Name:** CITY OF SPRINGFIELD **FEIN:** 046001415

**Employer D/B/A:**

**Employer Address:** 36 COURT STREET

**City | State | ZIP Code:** SPFLD. MA 01103

1. Did you offer a "Section 125 Cafeteria Plan" to this employee? Yes ☐ No ☐
2. Did you offer employer sponsored health insurance to this employee? Yes ☐ No ☐
3. If you offered sponsored insurance to this employee, what is the dollar amount of the employee's portion of the monthly premium cost of the least expensive individual health plan offered by the employer to the employee? (If did not offer sponsored insurance, leave blank.) $

## Employee

*Employees: please complete this section. See reverse side for instructions.*

**Employee First Name** **Middle Initial**

**Employee Last Name** **Suffix** (e.g., Sr., Jr.)

1. Did you accept your employer sponsored health insurance? Yes ☐ No ☐ None Offered ☐
2. Did you agree to use your employer's "Section 125 Cafeteria Plan" to purchase health insurance? Yes ☐ No ☐ None Offered ☐
3. Do you have other health insurance? Yes ☐ No ☐

### Employee Affidavit

I hereby affirm, under penalties of perjury, that all the information provided herein is true to the best of my knowledge. I also understand that if I do not have health insurance I may be responsible for the full costs of all medical treatment, that I may forfeit all or a portion of my Massachusetts personal tax exemption and be subject to other penalties pursuant to M.G.L c. 111M, that the Employee Health Insurance Responsibility Disclosure (HIRD) Form contains information that must be reported in my Massachusetts tax return, and that I am required to maintain a copy of the signed HIRD Form.

**Employee Signature** **Date (MM/DD/YY)** ☐☐/☐☐/☐☐

The employer must retain this document for three (3) years and make it available upon request to the Division of Health Care Finance and Policy and the Department of Revenue as required by state regulation 114.5 CMR 18.00.

# Instructions

### Employer Information

**Employer Name**
Employers must enter the company's legal name.

**FEIN**
The employer must enter the Federal Employer Identification Number.

**D/B/A**
The employer must enter the company's trade name "Doing Business As" here, if applicable.

**Employer Address**
The employer must enter the business address including city, state, and ZIP Code.

**Question 1**
The employer must indicate either Yes or No (check box).

**Question 2**
The employer must indicate either Yes or No (check box).

**Question 3**
The employer must report the dollar amount of the employee's portion of the monthly premium cost of the least expensive individual health plan offered by the employer to the employee, if the employer offers a sponsored health plan (i.e. the employer offers to pay for a portion of the premium).

### Employee Information

**Employee First Name**
The employee or employer must enter the employee's first name.

**Employee Last Name**
The employee or employer must enter the employee's last name.

**Question 1**
The employee must indicate Yes, No, or None Offered if health insurance is not offered (check box).

**Question 2**
The employee must indicate Yes, No, or None Offered if a "Section 125 Cafeteria Plan" is not offered (check box).

**Question 3**
The employee must indicate Yes or No (check box).

**Employee Signature**
The employee must sign and date the Employee Health Insurance Responsibility Disclosure (HIRD) form.

**Note to Employer Regarding Employee Signature**
If the employee refuses to sign and date the form, the refusal should be noted in writing and signed by the authorized company representative (e.g., the owner, supervisor or manager, chief executive officer, etc.).

### Alternate Versions of This Form

Employers may recreate their own version of the Employee Health Insurance Responsibility Disclosure (HIRD) form. However, all information must be included, with the same wording and order, and the sequence and numbering of the Questions must be exactly as it appears on the version provided by the Commonwealth of Massachusetts.

Commonwealth of Massachusetts
Group Insurance Commission
Your Benefits Connection

# Municipal Employee Acknowledgement Form

You are responsible for familiarizing yourself with your benefit options and making your elections within 10 days of the date of hire:

- Health Insurance
- Pre-tax Health Insurance Benefits (Section 125 Plan)
- Summary of Benefits and Coverage (www.mass.gov/gic/sbc)

Your signature is required on this form before your municipality can process your benefit elections. Please sign, date and return this form to your GIC Coordinator after you have reviewed the *Benefit Decision Guide*.

I hereby acknowledge that I have reviewed the most recent GIC *Benefit Decision Guide* and understand my benefit options before I made my benefit elections.

Name: _____
(Please print)

Signature: _____

Social Security Number: _____

Date: _____

*Employee:* Return this signed form to your GIC Coordinator/Benefits Office with your benefit elections.
*GIC Coordinator:* Give employee copy of this form and retain original signed form in employee's personnel file. Do not send to the GIC.

Commonwealth of Massachusetts
Group Insurance Commission

**Return completed form to the GIC Coordinator at your City/Town Benefits Office. Do not return to the GIC**

# Municipal Insurance Enrollment and Change Form (FORM -1MUN)

01 ☐ Be sure all information below is completed

| Insured's GIC-ID (usually Soc. Sec. #) | Sex: Male ☐ Female ☐ | Date of Birth | Dept. ID # or Agency/Division # |
|---|---|---|---|
| — — | | / / | 666/ |

| Name - Last | First | MI | Check one: ☐ Active Employee ☐ Retiree ☐ Survivor |
|---|---|---|---|

| Address | ☐ This is a new address | City | State | Zip Code |
|---|---|---|---|---|
| | | | | |

| Date of Hire (required for new enrollment) | City or Town employed or retired from | Home Phone | Work Phone |
|---|---|---|---|
| / / | | ( ) | ( ) |

02 ☐ **HEALTH COVERAGE** — **Effective Date: / 01 /**

New Enrollment ☐ | Change ☐ | Cancel Coverage ☐ | Reinstatement after military leave ☐

**NEW ENROLLMENTS – FOR AGENCY USE ONLY**

Does the employee participate in a public retirement system? ☐ Yes ☐ No

Number work hours/week _____

☐ **Health** (Select one of the health plans below and individual or family coverage)

**Health Plan – Active Employees and Non-Medicare Retirees/Survivors**

- ☐ Fallon Direct (HMO)
- ☐ Fallon Select (HMO)
- ☐ Harvard Pilgrim Independence (PPO)
- ☐ Harvard Pilgrim Primary Choice (HMO)
- ☐ Health New England (HMO)
- ☐ NHP Care – Neighborhood Health Plan (HMO)
- ☐ Tufts Health Plan Navigator (PPO)
- ☐ Tufts Health Plan Spirit (HMO-type)
- ☐ UniCare State Indemnity/Basic CIC: ☐ Yes ☐ No
- ☐ UniCare/Community Choice (PPO-type)
- ☐ UniCare/PLUS (PPO-type)

Coverage
- ☐ Individual
- ☐ Family

03 ☐ **Name Change** | Previous Name | New Name

## INSURED CHANGES

**FOR GIC USE ONLY:** **Effective Date: / 01 /**

06 ☐ **Retirement** Date Retired / / Medicare Eligible Attach copy of Medicare claim card (check if applicable) ☐ Insured ☐ Spouse Medicare Plan Name _____

07 ☐ **Transfer to another Agency /Municipality** Name of Agency/Municipality Transferred to Effective Date / /

08 ☐ **Transfer from another Agency/Municipality** Previous Agency/Municipality Effective Date / /

09 ☐ **Termination Coverage (if elected)** Termination Reason _____ Last Day at Work ____/____/____

☐ 39 -Week Layoff Coverage ☐ Deferred Retiree ☐ COBRA (must complete COBRA application) ☐ Conversion (contact carrier for application)

School Department employees who leave employment at the end of the school year only: Termination date ____/____/____ Premiums paid through ____/____/____

**SIGNATURE REQUIRED**

**Deduction Authorization**
I authorize my employer, or direct my pension authority , to deduct from my payroll or pension check the amount required for the coverage I have selected.

**Health Insurance:** I understand that once I choose a health plan, I cannot change plans until the next annual enrollment, even if my doctor or hospital leaves the plan.

**At Retirement**
I hereby certify that I have filed an application for retirement and desire to continue my present coverage as a retiree. I also understand that if I am Medicare eligible, I am required to join one of the Group Insurance Commission's Medicare supplemental health plans to continue health coverage.

**Survivors**
I am a surviving spouse and certify that I have not remarried and understand that if I do remarry I am no longer eligible for GIC coverage.

**Termination**
I understand that by electing to continue coverage under COBRA or Conversion, I must complete and return the corresponding application in order for this coverage to go into effect.

• If you are applying for Health Insurance, be sure to file a Form IDF to list family members.

x _____ Signature of Applicant Date

x _____ Signature of Authorized Official Date

| FOR GIC USE ONLY: | Entered | Verified | Political Subdivision |
|---|---|---|---|
| | | | |

Commonwealth of Massachusetts
Group Insurance Commission

P.O. Box 8747 • BOSTON, MA 02114-8747
(617) 727-2310 www.mass.gov/gic

# INSURANCE DATA FORM (IDF)

*PLEASE PRINT CLEARLY*

This form is required for new enrollments in any Group Insurance Commission family health plan and for any changes in spouse or dependents. Return the form to your GIC Coordinator. If you are a retiree, please return the form to the GIC. Please PRINT clearly. Incomplete forms will be returned.

**CHECK ONE:** ☐ **NEW MEMBER** ☐ **ADDITION** ☐ **DELETION** ☐ **CORRECTION**

**Important:** You are required to provide a copy of a marriage certificate, birth certificate, separation agreement, divorce decree, certificate of appointment as legal guardian, etc., for each person you list as a dependent. Failure to provide this documentation will result in your spouse/dependent not being covered. If you are deleting a spouse or dependent under age 19, you must provide proof of other coverage.

## INSURED INFORMATION

1) Social Security Number _____ – _____ – _____ 2) Date of Birth _____ / _____ / _____ (Month / Day / Year) 3) Sex ☐ M ☐ F

4) Name _____ (Last / First / Middle)

5) Address _____ (Street)

_____ (City / State / Zip Code)

6) Are you enrolled in Medicare? ☐ Yes ☐ No If yes, Medicare claim # _____

7) Health Plan (Check one)
- ☐ Fallon Direct (HMO)
- ☐ Fallon Select (HMO)
- ☐ Harvard Pilgrim Independence (PPO)
- ☐ Harvard Pilgrim Primary Choice (HMO)
- ☐ Health New England (HMO)
- ☐ NHP Care-Neighborhood Health Plan (HMO)
- ☐ Tufts Health Plan Navigator (PPO)
- ☐ Tufts Health Plan Spirit (HMO-type)
- ☐ UniCare State Indemnity/Basic
- ☐ UniCare/Community Choice (PPO-type)
- ☐ UniCare/PLUS (PPO-type)
- ☐ Medicare Plan — Fill in name of Medicare Plan _____

## SPOUSE/DEPENDENT INFORMATION

List below all family members, including your spouse or former spouse (if eligible), who will be covered under your family plan. Please provide all Social Security Numbers (required under Federal Law Section 111) and **exact** dates of birth for each dependent. Attach separate sheet if additional space is required. To add a dependent age 19 to 26, you must also complete and return to the GIC a Dependent Age 19 to 26 Enrollment Form.

| Last Name | First | Middle | Relationship | Date of Birth | Sex | Social Security Number (required) |
|---|---|---|---|---|---|---|
| | | | | | | – – |
| | | | | | | – – |
| | | | | | | – – |
| | | | | | | – – |
| | | | | | | – – |

Reason for addition or deletion: _____ Effective date: _____

## SPOUSE INFORMATION – Only complete if covering a spouse

Is your spouse employed? ☐ Yes ☐ No Name of employer _____ Address of employer _____

Is your spouse covered under his or her employer's group health insurance plan? ☐ Yes ☐ No Name of insurance company _____

Policy/Certificate Number _____ Address of insurance company _____

Are you and/or your children covered under your spouse's group health insurance plan? You: ☐ Yes ☐ No Children: ☐ Yes ☐ No

Is your spouse enrolled in Medicare? ☐ Yes ☐ No If yes, Medicare claim number _____

## FORMER SPOUSE INFORMATION – Only complete if covering a former spouse

Name _____ (Last / First / Middle) Social Security Number _____ – _____ – _____ Date of Birth _____ Date of Divorce _____

Address _____ (Street / City / State / Zip Code)

Is your former spouse remarried? ☐ Yes ☐ No If yes, date of remarriage _____ Are you remarried? ☐ Yes ☐ No If yes, date of remarriage _____

Is your former spouse employed? ☐ Yes ☐ No Name of employer _____

Is your former spouse covered under his or her employer's group health insurance plan? ☐ Yes ☐ No

## IMPORTANT: YOU MUST SIGN BELOW

Signed under the pains and penalties of perjury, I certify that the information I have provided is, to the best of my knowledge, complete and accurate.

Signature _____ Date _____

ACTIVE EMPLOYEES: RETURN COMPLETED FORM TO YOUR GIC COORDINATOR. **RETIREES:** RETURN COMPLETED FORM TO THE GIC

Form IDF 3/13

**FOR GIC COORDINATOR USE ONLY** **Dept. ID # or Agency/Division #** _____

Name of GIC Coordinator _____ Agency Telephone Number _____

Agency Name _____

Agency Address _____

**FOR GIC USE ONLY**

Entered _____

Verified _____

Date _____

Commonwealth of Massachusetts
Group Insurance Commission
Your Benefits Connection

## DEPENDENT AGE 19 TO 26 ENROLLMENT AND 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. Applications for dependents of existing GIC enrollees who are already over age 19 will be effective beginning on the first day of the second month after the GIC's receipt of this form. 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

_____

City State Zip

PLEASE COMPLETE ONLY ONE SECTION BELOW
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 _____

(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

I understand that if my dependent is not a full-time student he/she must reside in my health plan's service area. If you are not sure, the GIC health plan service areas are listed in the GIC *Benefit Decision Guide* (available on our website, www.mass.gov/gic) or you may contact your health plan directly. If your dependent does not live in your health plan's service area and is not a full-time student, you must change health plans. The UniCare Indemnity Plan Basic is the only nationwide plan. ***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**

Rev 3/7/13

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