INTERNATIONAL GROUP PLANS ENROLLMENT FORM

RESET FORM

A. GENERAL INFORMATION (ALL SPACES MUST BE COMPLETED)

Employer name: _____ Employer number: _____

Employee last name: _____ First: _____ MI: _____

Birthdate: _____ Social Security number: _____

Email: _____ Telephone: _____

Mailing address: _____

City: _____ State: _____ ZIP code: _____

Country of destination: _____ Airport code: _____ Effective date: _____

Gender: ☐ Male ☐ Female Marital status: ☐ Married ☐ Single

Employee classification: _____ Monthly Salary: $_____

Date of initial eligibility: _____ Coverage effective date: _____

B. BENEFIT ELECTION

Medical

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

Stateside coverage (select one): Select one _____

Overseas coverage (select one): 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 is not considered "creditable coverage" under Medicare Part D for active participants age 65 and older.

Dental

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

Stateside coverage (select one): Select one _____

Global coverage (select one): Select one _____

*Dental ID number required; please provide on page 2.

Vision

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

Stateside coverage (select one): Select one _____

Term Life Plans

Employee Term Life (employer base life): ☐ Yes ☐ No (Amount: $_____)

Employee Optional Term Life*: ☐ Yes ☐ No

Spouse Term Life (employer base): ☐ Yes ☐ No

Spouse Optional Term Life*: ☐ Yes ☐ No

Child Term Life: ☐ Yes ☐ No

*Requires a separate *Evidence of Good Health Application*.

Continued on other side

Employee name: _____ Social Security number: _____

Accidental Death & Dismemberment (AD&D) ☐ Yes ☐ No

Disability Plans

Short-term Disability ☐ Yes ☐ No Select one: Select one

Long-term Disability ☐ Yes ☐ No Select one: Select one

Supplemental AD&D

For myself ☐ Yes ☐ No Amount: $_____

For my spouse ☐ Yes ☐ No Amount: $_____ (50% of employee value)

C. 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. If an eligible spouse is over the age of 45 and does not have a social security number, an individual taxpayer identification number will be required for medical, dental, and/or vision enrollment. A copy of their ITIN assignment letter should accompany the enrollment form.

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

- Biological child
- Stepchild
- Foster child
- Child or grandchild for whom you or your spouse is the legal guardian or managing conservator
- Child whom 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
- Adopted child or child placed in home for adoption

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

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

D. NOTES

_____

_____

E. REQUIRED SIGNATURES

I authorize my employer to arrange for me to be covered under the terms of the plans I have chosen. I also authorize my employer to make any required deductions from my earnings as my contribution to the cost of this coverage.

Employee signature: _____ Date: _____

Employer Authorized Representative signature: _____ Date: _____

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