INTERNATIONAL EMPLOYEE ANNUAL CHANGE REQUEST GROUP PLANS
(Annual Open Enrollment Form)

Note: Complete and return this form to your employer to change your coverage option(s) to the plans listed below. Your employer will need to return this form to GSFR. The coverage available for your selection is contingent upon your employer's enrollment and participation in the plan.

EMPLOYEE INFORMATION (Please provide dependent information on the reverse side, if applicable.)

Employee first name: ______________ MI: ___ Last: ______________ Effective date: 1/1/2024

Employee mailing address: ______________

City: ______________ State: ________ ZIP code: ________

Social Security number (last four digits): ________ Email: ______________

Telephone: (_____) ______________ Classification:

Please provide dependent information on the reverse side, if applicable.

EMPLOYER INFORMATION

Employer name: ______________

Employer address: ______________

City: ______________ State: ________ ZIP code: ________

Employer number: 71061 Email: ______________

MEDICAL PLAN OPTIONS

Coverage option (please check): ☐ For myself ☐ For spouse ☐ For eligible children

Overseas coverage (select one):

If electing no coverage, you must also complete and submit the *International Global Worker Waiver of Medical Coverage Form*.

Global Health 3500 plan does not constitute "creditable coverage" for Massachusetts residents.

Continued on other side

© 2023 GSFR® 1195202 10/23 8802TIntlMTRZ

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.

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

- Biological child
- Stepchild
- Foster child
- Grandchild
- Child for whom you or your spouse is the legal guardian or managing conservator
- Child who 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

Last name	First name	MI	Social Security Number	Date of birth	Relationship	Sex M/F	Medical Y/N
			__________	______	Self	—	

* Your spouse and children under age 26 are eligible for coverage.

☐ I acknowledge that failure to adhere to the eligibility rules will result in the termination of coverage for the affected enrollee(s), and GSFR may require reimbursement for claims paid on behalf of ineligible enrollees.

AUTHORIZED SIGNATURES

Employee signature: ______________________________ Date: _____/_____/_____

Employer authorized representative signature: ______________________________ Date: _____/_____/_____

Employee name: ______________________________ Social Security number (last four digits): __________