MEDICAL AND/OR DENTAL APPLICATION AND CHANGE FORM

ENROLLEE (EMPLOYEE) INFORMATION

STEP 1

Last Name	First Name		MI
Mailing Address	City	State	Zip
Telephone	Is your position covered by a collective bargaining agreement? ❑ Yes ❑ No		
Employer Name	If yes, check the appropriate category: ❑ Teacher ❑ Police ❑ Fire ❑ Public Works ❑ Other		

Marital Status
- ❑ Single
- ❑ Married
- ❑ Widowed
- ❑ Divorced/Legally Separated
- ❑ Other________

TYPE OF COVERAGE AND MEMBERSHIP REQUESTED (check)

Medical Type	Medical Membership	Dental Type	Dental Membership
❑ HMO* ❑ Access Blue New England ❑ Site of Service Access Blue New England ❑ HDHP (Lumenos) ❑ Medicare Supplemental (Medicomp) ❑ With RX ❑ Without RX	❑ Single ❑ Two-Person ❑ Family	Dental Option #________	❑ Single ❑ Two-Person ❑ Family

*A PCP must be selected for HMO and is strongly recommended for POS.

STEP 2

REASON FOR COMPLETING FORM

- ❑ New Enrollee
- ❑ Benefit Change
- ❑ Open Enrollment
- ❑ Name Change
- ❑ Marriage
- ❑ Birth/Adoption
- ❑ Death
- ❑ Divorce/Legal Separation
- ❑ Dependent No Longer Eligible

Dependent Name ________

- ❑ Loss of Other Coverage (explain) ________
- ❑ Election of COBRA Coverage
- ❑ Part-Time to Full-Time
- ❑ Other (explain) ________

Actual Date of Event ________

Office Use Only

ENROLLEE AND DEPENDENT INFORMATION (Complete this section as your membership should appear)

STEP 3

NAME (First, MI, Last)	Social Security #	Date of Birth Month/Day/Year	Relation to Enrollee	Gender	Enroll(ed) in		Primary Care Provider (for HMO or POS Medical Type)		Current Patient
					Medical	Dental	PCP ID#	First/Last Name/City/State	
Employee Name			Self	❑ M ❑ F	❑	❑			❑ Y ❑ N
Spouse Name			Spouse	❑ M ❑ F	❑	❑			❑ Y ❑ N
Dependent Child Name**				❑ M ❑ F	❑	❑			❑ Y ❑ N
Dependent Child Name**				❑ M ❑ F	❑	❑			❑ Y ❑ N
Dependent Child Name**				❑ M ❑ F	❑	❑			❑ Y ❑ N

**If you are enrolling a dependent child age 26 or older who is disabled, complete a *Certification for a Mentally or Physically Disabled Child Over Maximum Age* form available through your employer or at *www.healthtrustnh.org*.

OTHER MEDICAL INSURANCE COVERAGE INFORMATION

STEP 4

Do you or your family have medical coverage through another group or employer? ❑ Y ❑ N

Are you or another dependent transferring coverage from another medical carrier? ❑ Y ❑ N

Member Name	Name of Insurance Company	
Policy Number	Effective Date	Termination Date

OTHER DENTAL INSURANCE COVERAGE INFORMATION

Do you or your family have dental coverage through another group or employer? ❑ Y ❑ N

Are you or another dependent transferring coverage from another dental carrier? ❑ Y ❑ N

Member Name	Name of Insurance Company	
Policy Number	Effective Date	Termination Date

Are you or any of your dependents eligible for Medicare? ❑ Y ❑ N
Member Name ________

Part A (Hospital) Effective Date
Part B (Medical) Effective Date

Medicare Claim Number________
Is coverage due to end-stage renal disease? ❑ Y ❑ N

ENROLLEE SIGNATURE

STEP 5

I hereby authorize HealthTrust and my employer to institute the enrollment(s) indicated on this form. If my employer requires a contribution for this coverage, this authorizes the appropriate payroll deductions. I understand that the effective date and termination date of my membership will be determined by HealthTrust and my employer in accordance with the plan rules. I understand that I must sign this form for claims to be processed. By signing this application, I attest to the accuracy and truthfulness and will provide documentation to HealthTrust upon request. I understand that any misrepresentation affecting the above named Enrollee's and/or Dependents' eligibility may result in retroactive cancellation of the medical and/or dental coverage and any charges incurred will be my liability. I understand it is my responsibility to notify my employer immediately when any Dependent no longer meets eligibility requirements of the plan.

Enrollee Signature Date Click to confirm your digital signature

EMPLOYER USE ONLY

STEP 6

Date of Hire	Date of Rehire	❑ Full-Time	❑ Part-Time Number of Hours Weekly	❑ COBRA	
Eligibility Organization Name				Employee Job Title	
Medical Group/Carrier Number	Coverage Code	Effective Date of Coverage		Benefits Administrator Signature/Stamp	Date
Dental Group/Carrier Number	Coverage Code	Effective Date of Coverage			

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White - HealthTrust Yellow - Employer Pink - Employee