HealthTrust

DENTAL APPLICATION AND CHANGE FORM

Please use this form to enroll in or change your dental coverage. Be sure to complete this entire form. If you only need to change your mailing address, do not complete this form; instead, log in to your account on HealthTrust's Secure Enrollee Portal (SEP), click on "Enrollment/Membership Info" and scroll to the bottom of the page and click on "Update your Membership Information."

BE SURE TO FILL OUT EACH SECTION COMPLETELY. Include information on all your eligible family members at initial enrollment and when making changes. Failure to complete each section in full could delay the start of coverage.

DENTAL COVERAGE

- Dependent children are generally eligible for coverage as of the first of the month following their second birthday. In order for your children to be covered, you must enroll them at that time; coverage is not automatic.
- You are required to enroll for a 12-month period. Voluntary cancellations or membership downgrades are not allowed during this period unless you terminate employment, your dependent is no longer eligible, or you experience a qualified family status change.

HOW TO COMPLETE THIS FORM

STEP 1	**ENROLLEE (EMPLOYEE) INFORMATION** Complete this section with your personal information, using your full legal name. Select the type of HealthTrust-sponsored dental coverage you are requesting and the membership type. Please limit your selection to only those coverages offered by your employer and for which you are eligible.
STEP 2	**REASON FOR COMPLETING FORM** Use this section to indicate the reason(s) for completing form. If you are current HealthTrust Enrollee making a change to your existing membership, you must include the actual date of event. Please see your employer or call HealthTrust to obtain additional forms that are required for divorce/legal separation or retirement.
STEP 3	**ENROLLEE AND DEPENDENT INFORMATION** Complete this section as your membership should appear at HealthTrust. If you need additional space, use the *Additional Dependent(s) Information* section on the last page of this form. • 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*. **Your dependent child will not be added to your coverage until approval of incapacitated status has been received by HealthTrust.**
STEP 4	**OTHER DENTAL INSURANCE COVERAGE INFORMATION** Complete this section if you or a covered family member will have other coverage along with this plan or are transferring from another group dental plan. If you choose to cover some, but not all of your eligible dependents, proof of other group coverage for those dependents you are not covering may be required.
STEP 5	**ENROLLEE SIGNATURE** Sign and date this form; return completed form to your employer.
STEP 6	**EMPLOYER USE ONLY** Employer must review form and verify that steps 1-5 are completed. Employer must complete this section and send via a secure message to HealthTrust Enrollee Services by logging in to your account on HealthTrust's Secure Member Portal and clicking on Message Center; forward to HealthTrust for processing at: PO Box 617, Concord, NH 03302; email to: *enrolleeservices@healthtrustnh.org*; or fax to: 603.226.2988

Questions? Please call us at 800.527.5001, Monday through Friday, 8:30 a.m. to 4:30 p.m.

DENTAL APPLICATION AND CHANGE FORM

STEP 1: ENROLLEE (EMPLOYEE) INFORMATION

First Name	MI	Last Name		
Mailing Address	City		State	ZIP
Telephone	Social Security #			
Employer Name				
Marital Status ☐ Single ☐ Married ☐ Divorced/Legally Separated ☐ Widowed ☐ Other _____	**TYPE OF COVERAGE AND MEMBERSHIP REQUESTED (check)**			
	Dental Type Dental Option #____		**Dental Membership** ☐ Single ☐ Two-Person ☐ Family	

STEP 2: REASON FOR COMPLETING FORM

☐ New Enrollee ☐ Open Enrollment ☐ Marriage ☐ Death ☐ Benefit Change ☐ Name Change	☐ Birth/Adoption ☐ Dependent No Longer Eligible (Dependent Name & **complete step 4**): _____ ☐ Divorce/Legal Separation ☐ Loss of Other Coverage (explain & **complete step 4**): _____ ☐ Part-Time to Full-Time ☐ Election of COBRA Coverage	☐ Other (explain): **Actual Date of Event**

STEP 3: ENROLLEE AND DEPENDENT INFORMATION (Complete this section as your membership should appear.)

NAME (First, MI, Last)	Date of Birth Month/Day/Year	Relation to Enrollee	Gender	HealthTrust Office Use Only
Employee Name		Self	☐Male ☐ Female	
Spouse Name		Spouse	☐Male ☐ Female	
Dependent Child Name			☐Male ☐ Female	
Dependent Child Name			☐Male ☐ Female	
Dependent Child Name			☐Male ☐ Female	

STEP 4: OTHER DENTAL INSURANCE COVERAGE INFORMATION

Do you or your family have dental coverage through another group or employer? ☐ Yes ☐ No	Name of Insurance Company	
Are you or another dependent transferring coverage from another dental carrier? ☐ Yes ☐ No	Policy Number	
Member Name	Effective Date	Termination Date

STEP 5: ENROLLEE SIGNATURE

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 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 _____

STEP 6: EMPLOYER USE ONLY

Date of Hire	Date of Rehire	☐ Full-Time ☐ Part-Time Number of Hours Weekly _____ ☐ COBRA
Billing Group Name		Employee Job Title
Dental Group/Carrier Number	Effective Date of Coverage	Benefits Administrator Signature/Stamp Date _____

Please complete section A, as necessary, and return with your application.

Enrollee Name _____ **Employer Name**_____

A. ADDITIONAL DEPENDENT(S) INFORMATION – If you are enrolling more than three dependent children, please complete the information below.

NAME (First, MI, Last)	Date of Birth Month/Day/Year	Relation to Enrollee	Gender
Dependent Child Name			☐Male ☐ Female
Dependent Child Name			☐Male ☐ Female
Dependent Child Name			☐Male ☐ Female
Dependent Child Name			☐Male ☐ Female
Dependent Child Name			☐Male ☐ Female
Dependent Child Name			☐Male ☐ Female

Enrollee Signature_____ Date _____