



RETIREE MEDICAL AND/OR DENTAL APPLICATION AND CHANGE FORM

A copy of your Medicare Parts A & B card must accompany this form if enrolling in Medicomp

Retiree's Name (First, MI, Last) _____ Phone _____ Gender M F
 DOB ____/____/____ SSN _____ Marital Status Single Married Widowed Divorced/Legally Separated
 Address _____

Former Employer Name _____

Spouse's Name _____ Gender M F
 DOB ____/____/____ SSN _____

HealthTrust Office Use ONLY

I. REASON FOR COMPLETING FORM

- | | | | |
|--|-----------------------------------|--|---|
| <input type="checkbox"/> Retirement | <input type="checkbox"/> Death | <input type="checkbox"/> Benefit Change | <input type="checkbox"/> Other (explain) _____ |
| <input type="checkbox"/> Retiree or Spouse Now Medicare Eligible | <input type="checkbox"/> Divorce | <input type="checkbox"/> Open Enrollment | <input type="checkbox"/> Loss of Other Coverage (explain) _____ |
| <input type="checkbox"/> New Enrollee | <input type="checkbox"/> Marriage | <input type="checkbox"/> COBRA Coverage Election | <input type="checkbox"/> Retirement Due to Disability |
- Actual Date of Event ____/____/____

II. RETIREE'S TYPE OF COVERAGE AND MEMBERSHIP REQUESTED

Medical Type	Medical Membership	Dental Type	Dental Membership
<input type="checkbox"/> HMO* <input type="checkbox"/> Access Blue New England* <input type="checkbox"/> Site of Service Access Blue New England* <input type="checkbox"/> POS (BlueChoice)* <input type="checkbox"/> Lumenos <input type="checkbox"/> Medicare Supplemental (Medicomp) <input type="checkbox"/> With RX <input type="checkbox"/> Without RX - Complete Page 2	<input type="checkbox"/> Single <input type="checkbox"/> Two-Person <input type="checkbox"/> Family	Dental Option # _____	<input type="checkbox"/> Single <input type="checkbox"/> Two-Person <input type="checkbox"/> Family
*A PCP must be selected for HMO and is strongly recommended for POS.			
*Primary Care Provider (PCP) ID # _____		*PCP First/Last Name/City/State _____	

III. SPOUSE'S/DEPENDENT(S)' TYPE OF COVERAGE AND MEMBERSHIP REQUESTED

Medical Type	Medical Membership	
<input type="checkbox"/> HMO* <input type="checkbox"/> Access Blue New England* <input type="checkbox"/> Site of Service Access Blue New England* <input type="checkbox"/> POS (BlueChoice)* <input type="checkbox"/> Lumenos <input type="checkbox"/> Medicare Supplemental (Medicomp) <input type="checkbox"/> With RX <input type="checkbox"/> Without RX - Complete Page 2	<input type="checkbox"/> Single <input type="checkbox"/> Two-Person <input type="checkbox"/> Family	If you have additional dependent(s) to be included on the membership or you're enrolling in MCNRX, please complete page 2.
*A PCP must be selected for HMO and is strongly recommended for POS.		
*Primary Care Provider (PCP) ID # _____		*PCP First/Last Name/City/State _____

IV. ADDITIONAL COVERAGE INFORMATION

Are you or any of your dependents eligible for or enrolled in Medicare? Yes No

Name _____ Medicare Claim Number _____ Submit a copy of your Medicare Parts A & B card Is coverage due to end-stage renal disease? <input type="checkbox"/> Yes <input type="checkbox"/> No	Name _____ Medicare Claim Number _____ Submit a copy of your Medicare Parts A & B card Is coverage due to end-stage renal disease? <input type="checkbox"/> Yes <input type="checkbox"/> No
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Medical	Dental
Do you currently have medical coverage through another plan (excluding Medicare)? <input type="checkbox"/> Yes <input type="checkbox"/> No Are you transferring coverage from another medical carrier? <input type="checkbox"/> Yes <input type="checkbox"/> No Subscriber Name _____ Medical Insurance Company _____ Effective Date ____/____/____ Termination Date ____/____/____	Do you currently have dental coverage through another plan? <input type="checkbox"/> Yes <input type="checkbox"/> No Are you transferring coverage from another dental carrier? <input type="checkbox"/> Yes <input type="checkbox"/> No Subscriber Name _____ Dental Insurance Company _____ Effective Date ____/____/____ Termination Date ____/____/____

V. SIGNATURES FOR Retiree and Spouse, if applicable

I hereby authorize HealthTrust and my former employer to institute the enrollment(s) indicated on the form. I understand that the effective date of my enrollment will be determined by HealthTrust and my former 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 Retiree's and/or Dependent's 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 former employer immediately when any Dependent no longer meets eligibility requirements of the plan.

Retiree's Signature _____ Date ____/____/____ Spouse's Signature _____ Date ____/____/____

VI. EMPLOYER USE ONLY

Eligibility Organization Name _____ Benefits Administrator Signature/Stamp _____ Date ____/____/____

Retiree
 Medical Group/Carrier Number _____ Coverage Code _____ Eff. Date of Coverage ____/____/____
 Dental Group/Carrier Number _____ Coverage Code _____ Eff. Date of Coverage ____/____/____

Spouse and/or Dependent
 Medical Group/Carrier Number _____ Coverage Code _____ Eff. Date of Coverage ____/____/____
 Dental Group/Carrier Number _____ Coverage Code _____ Eff. Date of Coverage ____/____/____

Additional Dependent(s) Information

Dependent Child Name (First, MI, Last) _____ DOB ____/____/____ Relation to Retiree _____ Gender M F
 Social Security # _____
 Enroll(ed) in Medical Dental *Primary Care Provider (PCP) ID # _____ *PCP Name _____

Dependent Child Name (First, MI, Last) _____ DOB ____/____/____ Relation to Retiree _____ Gender M F
 Social Security # _____
 Enroll(ed) in Medical Dental *Primary Care Provider (PCP) ID # _____ *PCP Name _____

Dependent Child Name (First, MI, Last) _____ DOB ____/____/____ Relation to Retiree _____ Gender M F
 Social Security # _____
 Enroll(ed) in Medical Dental *Primary Care Provider (PCP) ID # _____ *PCP Name _____

Medicomp Three without Prescription Drug Coverage (MCNRX) Election

Retiree and/or Spouse Name(s) _____
 (MCNRX Enrollee)

I hereby elect to enroll in the Medicomp Three **without** Prescription Drug Coverage (MCNRX) Plan and am indicating below my intent regarding enrolling in Medicare Part D.

_____ I understand that I also must now enroll in a Medicare Part D prescription drug plan in order to be eligible for a one-time opportunity to later return to my former employer's prescription drug plan for Retirees through HealthTrust. Provided that I enroll in Medicare Part D, I will have a one-time opportunity to return to my former employer's Medicomp Three **with** Prescription Drug Coverage Plan through HealthTrust within 24 months of this election of the MCNRX plan, but may return only at my former employer's open enrollment or a Medicare open enrollment. **If I do not return within 24 months, I understand that I will forfeit my right to return to prescription drug coverage through my former employer.**

_____ I do not intend to also enroll in a Medicare Part D prescription drug plan at this time. **I understand that I am therefore now forfeiting all rights to later return to my former employer's Medicomp Three with Prescription Drug Coverage plan for Retirees through HealthTrust.**

Retiree Signature _____ Date ____/____/____

Spouse Signature _____ Date ____/____/____

If payment for medical and/or dental premium will be deducted from the Retiree's NHRS annuity, a Retirement Annuity Deduction Authorization for Medical and Dental Benefits form must also be completed and submitted with this Retiree and/or Dental Application and Change Form.

To be completed by Groups that have elected HealthTrust's retiree billing services			
	MEDICAL		DENTAL
	Retiree	Spouse	
Group Pays:			
Enrollee Pays:			
TOTAL:			