HELPFUL HINTS WHEN COMPLETING THE *Medical and/or Dental Application and Change Form*

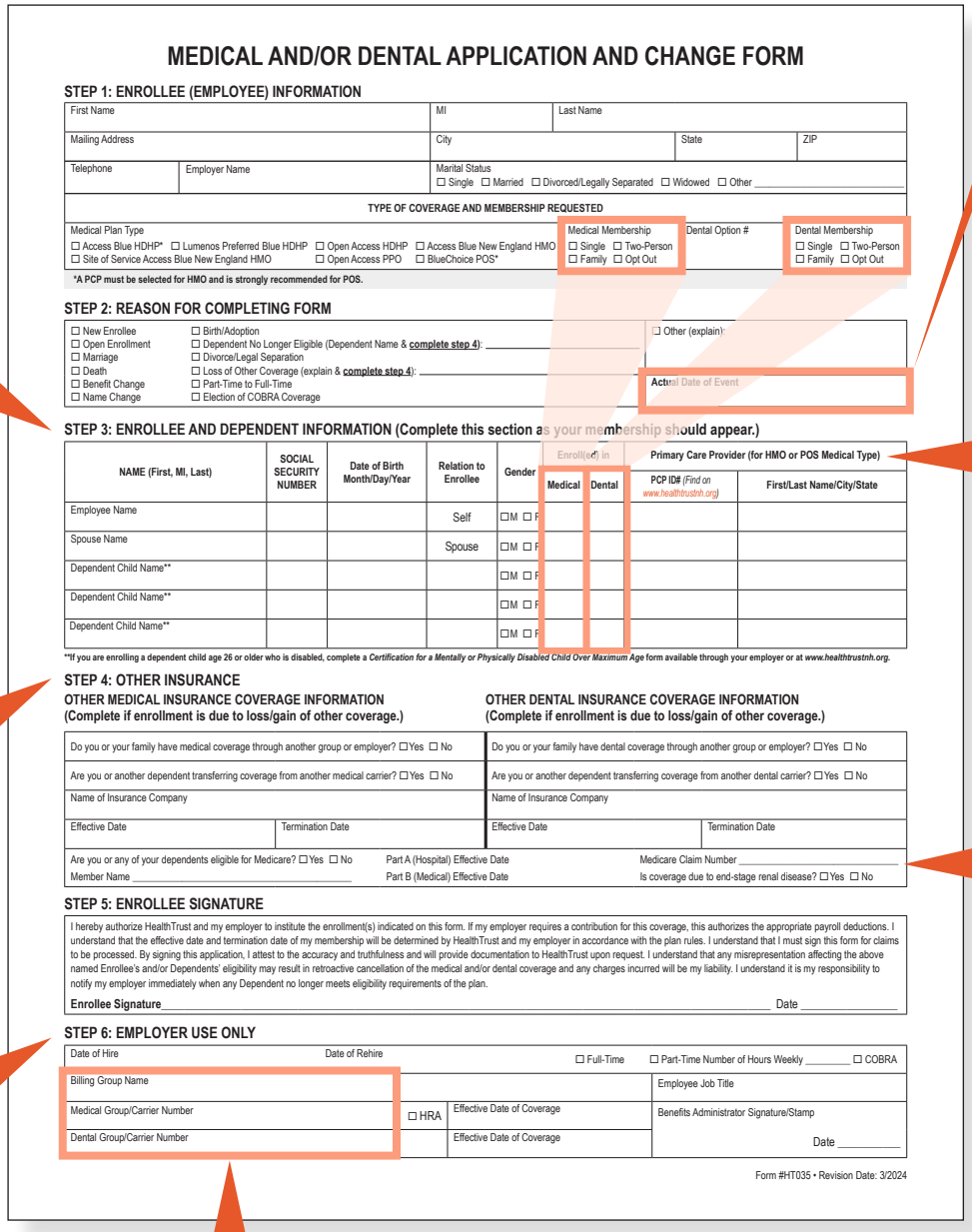
Ensure the Application is legible – if you can't read it, we can't read it either.

If requesting only a change to medical plan coverage and the enrollee also is enrolled in dental plan coverage, the information regarding dental coverage must also be indicated.

Step 3 should be completed as the membership should appear as of the requested effective date.

Step 4 must be completed when adding or removing a dependent due to loss of other group health coverage or acquiring other group health coverage.

Step 6 must be completed in its entirety by the Benefits Administrator.



MEDICAL AND/OR DENTAL APPLICATION AND CHANGE FORM

STEP 1: ENROLLEE (EMPLOYEE) INFORMATION

First Name	MI	Last Name	
Mailing Address	City	State	ZIP
Telephone / Employer Name	Marital Status ☐ Single ☐ Married ☐ Divorced/Legally Separated ☐ Widowed ☐ Other		

TYPE OF COVERAGE AND MEMBERSHIP REQUESTED

Medical Plan Type	Medical Membership	Dental Option #	Dental Membership
☐ Access Blue HDHP* ☐ Lumenos Preferred Blue HDHP ☐ Open Access HDHP ☐ Access Blue New England HMO ☐ Site of Service Access Blue New England HMO ☐ Open Access PPO ☐ BlueChoice POS*	☐ Single ☐ Two-Person ☐ Family ☐ Opt Out		☐ Single ☐ Two-Person ☐ Family ☐ Opt Out

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

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)	SOCIAL SECURITY NUMBER	Date of Birth Month/Day/Year	Relation to Enrollee	Gender	Enrolled in Medical	Enrolled in Dental	Primary Care Provider (for HMO or POS Medical Type) PCP ID# (Find on www.healthtrustnh.org)	Primary Care Provider (for HMO or POS Medical Type) First/Last Name/City/State
Employee Name			Self	☐M ☐F				
Spouse Name			Spouse	☐M ☐F				
Dependent Child Name**				☐M ☐F				
Dependent Child Name**				☐M ☐F				
Dependent Child Name**				☐M ☐F				

**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*.

STEP 4: OTHER INSURANCE

OTHER MEDICAL INSURANCE COVERAGE INFORMATION (Complete if enrollment is due to loss/gain of other coverage.)	OTHER DENTAL INSURANCE COVERAGE INFORMATION (Complete if enrollment is due to loss/gain of other coverage.)
Do you or your family have medical coverage through another group or employer? ☐Yes ☐ No	Do you or your family have dental coverage through another group or employer? ☐Yes ☐ No
Are you or another dependent transferring coverage from another medical carrier? ☐Yes ☐ No	Are you or another dependent transferring coverage from another dental carrier? ☐Yes ☐ No
Name of Insurance Company	Name of Insurance Company
Effective Date / Termination Date	Effective Date / Termination Date

Are you or any of your dependents eligible for Medicare? ☐Yes ☐ No
Member Name _____
Part A (Hospital) Effective Date
Part B (Medical) Effective Date
Medicare Claim Number _____
Is coverage due to end-stage renal disease? ☐Yes ☐ No

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 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 _____

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
Medical Group/Carrier Number	☐ HRA	Effective Date of Coverage	Benefits Administrator Signature/Stamp
Dental Group/Carrier Number		Effective Date of Coverage	Date _____

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Refer to your Group's *Carrier ID Table* for details. The Group Carrier Number must correlate with the Type of Coverage elected in Step 1.

Step 2 – Indicate the actual date of the event; do not indicate the requested coverage change effective date.

PCP selection is required for HMO plans and is strongly recommended for POS plans.

Step 4 – Make sure Medicare information is provided if the enrollee and/or spouse is Medicare eligible.

HealthTrust

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