HealthTrust

LIFE, LONG-TERM DISABILITY (LTD), AND/OR SHORT-TERM DISABILITY (STD) APPLICATION AND CHANGE FORM

WELCOME TO HEALTHTRUST

Use this form to change your beneficiary(ies) as well as to enroll in or change your disability and/or life insurance coverage. If you only need to change your mailing address, do not complete this form; instead, call HealthTrust's Enrollee Services Department at 800.527.5001 and notify your employer.

BE SURE TO FILL OUT EACH SECTION COMPLETELY. Failure to complete each section in full could delay the start of coverage.

HOW TO COMPLETE THIS FORM

Remove this cover sheet before you begin.

STEP 1	**EMPLOYEE INFORMATION** Complete this section with your personal information, using your full legal name. Select the type of HealthTrust-sponsored life and/or disability coverage you are requesting. Please limit your selection to only those coverages offered by your employer and for which you are eligible. Some life and disability coverages may require evidence of insurability. You will not be eligible for any amount greater than the evidence of insurability requirement if you do not submit an *Evidence of Insurability* form; this form may be obtained from your employer or HealthTrust. You will be added for an amount greater than the evidence of insurability requirement once approved. For more information, refer to your certificate of coverage.
STEP 2	**REASON FOR COMPLETING APPLICATION** Use this section to indicate the reason(s) for completing form.
STEP 3	**BENEFICIARY INFORMATION** Please name your beneficiary(ies) for your life and/or disability coverages. If you wish to name a different beneficiary(ies) for your life, long-term disability (LTD), and/or short-term disability (STD) coverages, attach a separate piece of paper containing all necessary information. Otherwise, your beneficiary(ies) will be the same for all coverages. You may name more than one beneficiary. If you specify benefit percentages, the total must equal 100 percent. If you do not specify benefit percentages, benefits will be paid in equal shares. If you do not name a beneficiary(ies) – or if neither your primary nor contingent beneficiary(ies) survive you – benefits will be paid in order of survivorship shown in your certificate of coverage. Your primary beneficiary(ies) are the person(s) you name to receive benefits. Your contingent beneficiary(ies) are the person(s) you name to receive benefits if your primary beneficiary(ies) do not survive you.
STEP 4	**EMPLOYEE SIGNATURE** Sign and date this form; return completed form to your employer (retain the pink copy for your records).
STEP 5	**EMPLOYER USE ONLY** Employer must review this form and verify that steps 1-4 are completed. Employer must complete this section and forward to HealthTrust for processing at: PO Box 617, Concord, NH 03302, or through the Secure Message Center in your Secure Member Portal (SMP) account, email enrolleeservices@healthtrustnh.org or fax 603.226.2988

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EMPLOYEE INFORMATION

STEP 1

Last Name	First Name	MI
Social Security #	Date of Birth	Gender ☐ Male ☐ Female
Mailing Address		Telephone
City	State	Zip
Employer Name		

Marital Status

☐ Single
☐ Married
☐ Widowed
☐ Divorced/Legally Separated

TYPE OF COVERAGE REQUESTED (check)

Life Coverage

☐ Basic Life
☐ Supplemental Life
☐ Dependent Life

Disability Coverage

☐ Long-Term Disability
☐ Short-Term Disability

STEP 2

REASON FOR COMPLETING FORM

☐ New Enrollee
☐ Benefit Change
☐ Part Time to Full Time
☐ Other _____
☐ Name Change
☐ Change in Beneficiary ONLY

Actual Date of Event _____

BENEFICIARY INFORMATION

STEP 3

Name of Beneficiary	Date of Birth	Relation to Employee	Social Security #	Benefit Percentage
Primary Beneficiary				%
Primary Beneficiary				%
Primary Beneficiary				%
				Total: 100%
Contingent Beneficiary				%
Contingent Beneficiary				%
				Total: 100%

ENROLLEE SIGNATURE

STEP 4

I hereby authorize HealthTrust and my employer to institute the action(s) indicated on this form. If my employer requires a contribution for this coverage, this authorizes the appropriate payroll deductions. I understand that the ef fective 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 and beneficiary designation(s) to be made valid. By signing this application, I at test to the accuracy and truthfulness and will provide documentation to HealthTrust upon request.

Enrollee Signature_____ Date ____/____/____

EMPLOYER USE ONLY

STEP 5

Date of Hire	Date of Rehire	Billing Group Name	
Full-Time Number of Hours	Part-Time Number of Hours	Base Annual Salary	Employee Job Title

Basic Life Coverage	Additional Life Coverage	Long-Term Disability Coverage	Short-Term Disability Coverage
Class Number	☐ Supplemental	Class Number	Class Number
Effective Date of Coverage	☐ Dependent	Effective Date of Coverage	Effective Date of Coverage
Basic Life Benefit Amount		Benefit Administrator Signature/Stamp	Date
Supplemental Life Benefit Amount			

HealthTrust

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