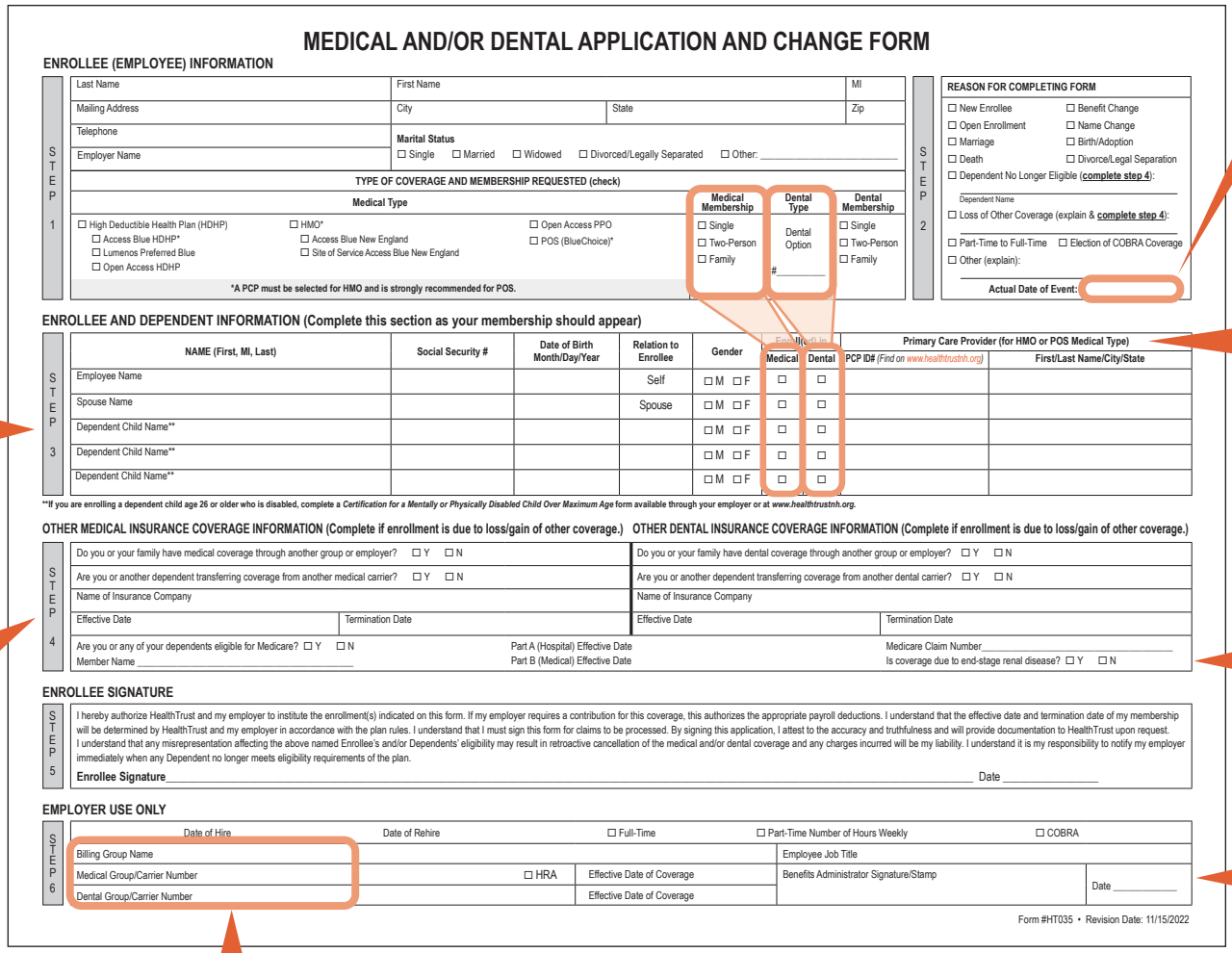
HELPFUL HINTS WHEN COMPLETING THE *Medical and/or Dental Application and Change Form*

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.



MEDICAL AND/OR DENTAL APPLICATION AND CHANGE FORM

ENROLLEE (EMPLOYEE) INFORMATION

STEP 1

Last Name | First Name | MI

Mailing Address | City | State | Zip

Telephone | Marital Status ☐ Single ☐ Married ☐ Widowed ☐ Divorced/Legally Separated ☐ Other: _____

Employer Name

TYPE OF COVERAGE AND MEMBERSHIP REQUESTED (check)

Medical Type			Medical Membership	Dental Type	Dental Membership
☐ High Deductible Health Plan (HDHP) ☐ Access Blue HDHP* ☐ Lumenos Preferred Blue ☐ Open Access HDHP	☐ HMO* ☐ Access Blue New England ☐ Site of Service Access Blue New England	☐ Open Access PPO ☐ POS (BlueChoice)*	☐ 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 (complete step 4): _____ Dependent Name
☐ Loss of Other Coverage (explain & complete step 4): _____
☐ Part-Time to Full-Time ☐ Election of COBRA Coverage
☐ Other (explain): _____
Actual Date of Event: _____

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	Enrolling in		Primary Care Provider (for HMO or POS Medical Type)	
					Medical	Dental	PCP ID# (Find on www.healthtrustnh.org)	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*.

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.)

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
Name of Insurance Company
Effective Date | Termination Date

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
Name of Insurance Company
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 _____

EMPLOYER USE ONLY

STEP 6

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 | Date _____

Dental Group/Carrier Number | Effective Date of Coverage

Form #HT035 • Revision Date: 11/15/2022

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

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

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.

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.

HealthTrust

Rev. 1/30/2023