

MEDICAL AND/OR DENTAL APPLICATION AND CHANGE FORM



Please use this form to enroll in or change your medical and/or dental coverage. Be sure to complete this entire form and retain the PINK copy to serve as your temporary ID card if needed. If you only need to change your mailing address, do not complete this form; instead, call HealthTrust Enrollee Services at 800.527.5001 **and** notify your employer.

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.

PRIMARY CARE PROVIDER (PCP) SELECTION

When you enroll in a BlueChoice® or Matthew Thornton BlueSM medical plan, each member of your family must choose their own PCP to coordinate medical care. Your PCP can be a family or general practitioner, an internist, or a pediatrician (for children). A Provider Directory can be accessed on-line at www.healthtrustnh.org by clicking on "Resources." Should you decide to change your PCP after initially enrolling with HealthTrust, do not fill out this form. Instead, call the Anthem Member Services number on the back of your medical ID card.

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

Remove this cover sheet before you begin

STEP 1	<p>ENROLLEE (EMPLOYEE) INFORMATION</p> <p>Complete this section with your personal information, using your full legal name. Select the type of HealthTrust-sponsored medical and/or dental coverage you are requesting and the membership type for each. Please limit your selection to only those coverages offered by your employer and for which you are eligible. If you are applying for the Medicare Supplemental plan, please complete the <i>Retiree Medical and/or Dental Application and Change Form</i>.</p>
STEP 2	<p>REASON FOR COMPLETING FORM</p> <p>Use this section to indicate the reason(s) for completing form. If you are a current HealthTrust enrollee making a change to your existing membership, you must include the <u>actual date of event</u>. Please see your employer or call HealthTrust to obtain additional forms that are required for divorce/legal separation or retirement.</p>
STEP 3	<p>ENROLLEE AND DEPENDENT INFORMATION</p> <p>Complete this section as your membership should appear at HealthTrust. If you need additional space, use the <i>Additional Dependent(s) Information</i> section on the last page of this form.</p> <ul style="list-style-type: none"> • If you are enrolling a dependent child age 26 or older who is disabled, complete a <i>Certification for a Mentally or Physically Disabled Child Over Maximum Age</i> 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. • If your HealthTrust-sponsored medical plan requires a PCP, you must provide a PCP name and PCP ID number (including all characters) for you and each of your covered dependents; indicate if you are a current patient.
STEP 4	<p>OTHER INSURANCE COVERAGE INFORMATION</p> <p>Complete this section if you or a covered family member will have other coverage along with this plan or are transferring from another group medical or 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.</p>
STEP 5	<p>ENROLLEE SIGNATURE</p> <p>Sign and date this form; return completed form to your employer.</p>
STEP 6	<p>EMPLOYER USE ONLY</p> <p>Employer must review form and verify that steps 1-5 are completed. Employer must complete this section and forward to HealthTrust for processing at: PO Box 617, Concord, NH 03302; email to: enrolleeservices@healthtrustnh.org; or fax to: 603.226.2988</p>

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

MEDICAL AND/OR DENTAL APPLICATION AND CHANGE FORM

ENROLLEE (EMPLOYEE) INFORMATION

S T E P 1	Last Name		First Name		MI	
	Mailing Address		City	State	Zip	
	Telephone		Email			
	Employer Name		Is your position covered by a collective bargaining agreement? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, check the appropriate category: <input type="checkbox"/> Teacher <input type="checkbox"/> Police <input type="checkbox"/> Fire <input type="checkbox"/> Public Works <input type="checkbox"/> Other			
	Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced/Legally Separated <input type="checkbox"/> Other _____		TYPE OF COVERAGE AND MEMBERSHIP REQUESTED (check)			
			Medical Type		Medical Membership	Dental Type
		<input type="checkbox"/> HMO <input type="checkbox"/> Matthew Thornton Blue <input type="checkbox"/> Access Blue New England <input type="checkbox"/> Site of Service <input type="checkbox"/> POS (BlueChoice) <input type="checkbox"/> HDHP (Lumenos) Benefit String: _____	<input type="checkbox"/> Indemnity (JY, JW, or Comp) <input type="checkbox"/> PPO (Preferred Blue) <input type="checkbox"/> Medicare Supplemental (Medicomp) <input type="checkbox"/> With RX <input type="checkbox"/> Without RX	<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	

S T E P 2	REASON FOR COMPLETING FORM	
	<input type="checkbox"/> New Enrollee <input type="checkbox"/> Benefit Change <input type="checkbox"/> Open Enrollment <input type="checkbox"/> Name Change <input type="checkbox"/> Marriage <input type="checkbox"/> Birth/Adoption <input type="checkbox"/> Death <input type="checkbox"/> Divorce/Legal Separation <input type="checkbox"/> Retirement Due to Disability	<input type="checkbox"/> Dependent No Longer Eligible Dependent Name _____ <input type="checkbox"/> Retirement <input type="checkbox"/> Retiree or Spouse Now Medicare Eligible <input type="checkbox"/> Loss of Other Coverage (explain) _____ <input type="checkbox"/> Election of COBRA Coverage <input type="checkbox"/> Other (explain) _____
	Actual Date of Event _____	
	Office Use Only	

ENROLLEE AND DEPENDENT INFORMATION (Complete this section as your membership should appear)

S T E P 3	NAME (First, MI, Last)	Social Security #	Date of Birth Month/Day/Year	Relation to Enrollee	Gender	Enroll(ed) in		Primary Care Provider (for HMO or POS Medical Type)		Current Patient	
	Employee Name		___/___/___	Self	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/>	<input type="checkbox"/>	PCP ID#	First/Last Name/City	<input type="checkbox"/> Y <input type="checkbox"/> N	
	Spouse Name		___/___/___	Spouse	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/> Y <input type="checkbox"/> N	
				Spouse Email							
	Dependent Child Name**		___/___/___		<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/> Y <input type="checkbox"/> N	
	Dependent Child Name**		___/___/___		<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/> Y <input type="checkbox"/> N	
	Dependent Child Name**		___/___/___		<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/> Y <input type="checkbox"/> N	

**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

S T E P 4	Do you or your family have medical coverage through another group or employer? <input type="checkbox"/> Y <input type="checkbox"/> N	
	Are you or another dependent transferring coverage from another medical carrier? <input type="checkbox"/> Y <input type="checkbox"/> N	
	Member Name	Name of Insurance Company
	Policy Number	Effective Date Termination Date
	Are you or any of your dependents eligible for Medicare? <input type="checkbox"/> Y <input type="checkbox"/> N	
Member Name _____		
Part A (Hospital) Effective Date ___/___/___		
Part B (Medical) Effective Date ___/___/___		

OTHER DENTAL INSURANCE COVERAGE INFORMATION

Do you or your family have dental coverage through another group or employer? <input type="checkbox"/> Y <input type="checkbox"/> N	
Are you or another dependent transferring coverage from another dental carrier? <input type="checkbox"/> Y <input type="checkbox"/> N	
Member Name	Name of Insurance Company
Policy Number	Effective Date Termination Date
Medicare Claim Number _____	
Is coverage due to end-stage renal disease? <input type="checkbox"/> Y <input type="checkbox"/> N	

ENROLLEE SIGNATURE

S T E P 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

S T E P 6	Date of Hire ___/___/___	Date of Rehire ___/___/___	<input type="checkbox"/> Full-Time	<input type="checkbox"/> Part-Time to Full-Time Date ___/___/___	<input type="checkbox"/> Part-Time Number of Hours Weekly _____	<input type="checkbox"/> COBRA	<input type="checkbox"/> Retiree
	Eligibility Organization Name				Employee Job Title		
	Medical Group/Carrier Number		Effective Date of Coverage ___/___/___		Benefits Administrator Signature/Stamp		Date ___/___/___
	Dental Group/Carrier Number		Effective Date of Coverage ___/___/___				

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)	Social Security #	Date of Birth Month/Day/Year	Relation to Enrollee	Gender	Enroll(ed) in		Primary Care Provider (for HMO or POS Medical Type)		Current Patient
					Medical	Dental	PCP #	First/Last Name/City	
Dependent Child Name**		___/___/___		<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/> Y <input type="checkbox"/> N
Dependent Child Name**		___/___/___		<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/> Y <input type="checkbox"/> N
Dependent Child Name**		___/___/___		<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/> Y <input type="checkbox"/> N
Dependent Child Name**		___/___/___		<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/> Y <input type="checkbox"/> N
Dependent Child Name**		___/___/___		<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/> Y <input type="checkbox"/> N
Dependent Child Name**		___/___/___		<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/> Y <input type="checkbox"/> N

**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.

Enrollee Signature _____ Date ___/___/___