MEDICAL AND/OR DENTAL APPLICATION AND CHANGE FORM

HealthTrust

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 Blue℠ 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 Customer Service number on the back of your medical ID card.

DENTAL COVERAGE

- Dependent children are 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	**ENROLLEE (EMPLOYEE) INFORMATION** 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. If you are applying for the Medicare Supplemental plan, please complete the *Retiree Medical and/or Dental Application and Change Form*.
STEP 2	**REASON FOR COMPLETING FORM** 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 actual date of event. Please see your employer or call HealthTrust to obtain additional forms that are required for divorce/legal separation or retirement.
STEP 3	**ENROLLEE AND DEPENDENT INFORMATION** Complete this section as your membership should appear at HealthTrust. If you need additional space, use the *Additional Dependent Information* section on the last page of this form. • If you are enrolling a dependent(s) 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.* **Your dependent 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 ID number (including all characters) for you and each of your covered dependents; indicate if you are a current patient.
STEP 4	**OTHER INSURANCE COVERAGE INFORMATION** 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 two-person coverage for yourself and your child, you must include proof or your spouse's coverage.
STEP 5	**ENROLLEE SIGNATURE** Sign and date this form, return completed form to your employer.
STEP 6	**EMPLOYER USE ONLY** 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

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

Form #HT035
Revision Date 11/14

MEDICAL AND/OR DENTAL APPLICATION AND CHANGE FORM

ENROLLEE (EMPLOYEE) INFORMATION

STEP 1

Last Name	First Name		MI
Mailing Address	City	State	Zip
Telephone	Email		
Employer Name	Is your position covered by a collective bargaining agreement? ❑ Yes ❑ No If yes, check the appropriate category: ❑ Teacher ❑ Police ❑ Fire ❑ Public Works ❑ Other		

Marital Status
- ❑ Single
- ❑ Married
- ❑ Widowed
- ❑ Divorced/Legally Separated
- ❑ Other_____

TYPE OF COVERAGE AND MEMBERSHIP REQUESTED (check)

Medical Type	Medical Membership	Dental Type	Dental Membership
❑ Indemnity (JY, JW or Comp) ❑ HMO (Matthew Thornton) ❑ POS (BlueChoice) ❑ PPO ❑ Health Savings Account (HSA) ❑ Medicare Supplemental ❑ With RX ❑ Without RX ❑ Site of Service ❑ Matthew Thornton ❑ Access Blue Benefit String:_____	❑ Single ❑ Two-Person ❑ Family	Dental Option #_____	❑ Single ❑ Two-Person ❑ Family

STEP 2

REASON FOR COMPLETING FORM
- ❑ New Enrollee
- ❑ Benefit Change
- ❑ Open Enrollment
- ❑ Name Change
- ❑ Marriage
- ❑ Birth/Adoption
- ❑ Death
- ❑ Divorce/Legal Separation
- ❑ Retirement Due to Disability

Actual Date of Event
_____

- ❑ Dependent No Longer Eligible

Dependent Name _____
- ❑ Retirement
- ❑ Retiree or Spouse Now Medicare Eligible
- ❑ Loss of Other Coverage (explain) _____
- ❑ Election of COBRA Coverage
- ❑ Other (explain) _____

Office Use Only

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	Enroll(ed) in		Primary Care Provider (for HMO or POS Medical Type)		Current Patient
					Medical	Dental	PCP ID#	First/Last Name	
Employee Name		____/____/____	Self	❑ M ❑ F	❑	❑			❑ Y ❑ N
Spouse Name		____/____/____	Spouse	❑ M ❑ F	❑	❑			❑ Y ❑ N
		Spouse Email							
Dependent Name**		____/____/____		❑ M ❑ F	❑	❑			❑ Y ❑ N
Dependent Name**		____/____/____		❑ M ❑ F	❑	❑			❑ Y ❑ N
Dependent Name**		____/____/____		❑ M ❑ F	❑	❑			❑ Y ❑ N

If you are enrolling a dependent(s) 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

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

Member Name	Name of Insurance Company	
Policy Number	Effective Date	Termination Date

Are you or any of your dependents eligible for Medicare? ❑ Y ❑ N

Part A (Hospital) Effective Date ____/____/____

Medicare Claim Number_____

Part B (Medical) Effective Date ____/____/____

OTHER DENTAL INSURANCE COVERAGE INFORMATION

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

Member Name	Name of Insurance Company	
Policy Number	Effective Date	Termination 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 will 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 to Full-Time	❑ Part-Time Number of Hours Weekly_____	❑ COBRA	❑ 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 ____/____/____				

White - HealthTrust Yellow - Employer Pink - Employee

Form #HT035
Revision Date 11/14

Please complete section A, as necessary, and return with your application.

Enrollee Name ______________________________ **Employer Name** ______________________________

A. ADDITIONAL DEPENDENT INFORMATION – If you are enrolling more than two dependents, 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	
Dependent Name**		___/___/___		❑ M ❑ F	❑	❑			❑ Y ❑ N
Dependent Name**		___/___/___		❑ M ❑ F	❑	❑			❑ Y ❑ N
Dependent Name**		___/___/___		❑ M ❑ F	❑	❑			❑ Y ❑ N
Dependent Name**		___/___/___		❑ M ❑ F	❑	❑			❑ Y ❑ N
Dependent Name**		___/___/___		❑ M ❑ F	❑	❑			❑ Y ❑ N
Dependent Name**		___/___/___		❑ M ❑ F	❑	❑			❑ Y ❑ N

****If you are enrolling a dependent(s) 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 ___/___/___