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. If you only need to change your mailing address, do not complete this form; instead, log in to your account on HealthTrust's Secure Enrollee Portal (SEP), click on "Enrollment/Membership Info" and scroll to the bottom of the page and click on "Update your Membership Information."

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 Access Blue New England℠ 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). To access a Provider Directory, visit *www.healthtrustnh.org* and click on the medical icon, then click on the orange button with your plan type. 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

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. 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 *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(s) Information* section on the last page of this form. • 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*. **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	**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 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.
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 send via a secure message to HealthTrust Enrollee Services by logging in to your account on HealthTrust's Secure Member Portal and clicking on Message Center; forward to HealthTrust for processing at: PO Box 617, Concord, NH 03302; email to: *enrolleeservices@healthtrustnh.org*; or fax to: 603.226.2988

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

Form #HT035
Revision Date: 11/15/2022

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
☐ BC3T5RDR - RX10/20/45 ☐ BC3T15IPDED - RX10/20/45 ☐ AB5 - RX 10/20/45 ☐ AB20IPDED RX 10/20/45	☐ 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	Enroll(ed) 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.)

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

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

Member Name _____

Part A (Hospital) Effective Date

Part B (Medical) Effective Date

OTHER DENTAL INSURANCE COVERAGE INFORMATION (Complete if enrollment is due to loss/gain of other coverage.)

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

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 Monadnock Regional School District SAU 93 | Employee Job Title

Medical Group/Carrier Number 363059M ☐ HRA | Effective Date of Coverage | Benefits Administrator Signature/Stamp | Date _____

Dental Group/Carrier Number 3116- | 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)	
					Medical	Dental	PCP ID# *(Find on Anthem.com)*	First/Last Name/City/State
Dependent Child Name**				☐ M ☐ F	☐	☐		
Dependent Child Name**				☐ M ☐ F	☐	☐		
Dependent Child Name**				☐ 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*.**

Enrollee Signature _____ Date _____