



# RETIREE MEDICAL AND/OR DENTAL APPLICATION AND CHANGE FORM

A copy of your Medicare Parts A & B card must accompany this form if enrolling in the HealthTrust Medicare Advantage with Prescription Drug (MAPD) plan.

Retiree's Name (First, MI, Last) \_\_\_\_\_ Phone \_\_\_\_\_ Gender  M  F

DOB \_\_\_\_/\_\_\_\_/\_\_\_\_ SSN \_\_\_\_\_ Marital Status  Single  Married  Widowed  Divorced/Legally Separated

Physical Address (must be a street address, NOT a P.O. Box) \_\_\_\_\_

Mailing Address (if different) \_\_\_\_\_

Former Employer Name \_\_\_\_\_

**Notes**

Spouse's Name \_\_\_\_\_ Gender  M  F

DOB \_\_\_\_/\_\_\_\_/\_\_\_\_ SSN \_\_\_\_\_

### I. REASON FOR COMPLETING FORM

<input type="checkbox"/> Retirement	<input type="checkbox"/> Death	<input type="checkbox"/> Benefit Change	<input type="checkbox"/> Other (explain) _____
<input type="checkbox"/> Retiree or Spouse Now Medicare Eligible	<input type="checkbox"/> Divorce	<input type="checkbox"/> Open Enrollment	<input type="checkbox"/> Loss of Other Coverage (explain) _____
<input type="checkbox"/> New Enrollee	<input type="checkbox"/> Marriage	<input type="checkbox"/> Retirement Due to Disability	Actual Date of Event ____/____/____

### II. RETIREE'S TYPE OF COVERAGE AND MEMBERSHIP REQUESTED

Medical Plan Type	Medical Membership	Dental Type	Dental Membership
<input type="checkbox"/> High Deductible Health Plan (HDHP) <input type="checkbox"/> HMO* <input type="checkbox"/> HealthTrust Medicare Advantage (MAPD) <input type="checkbox"/> Access Blue HDHP* <input type="checkbox"/> Access Blue New England <input type="checkbox"/> Open Access PPO <input type="checkbox"/> Lumenos Preferred Blue <input type="checkbox"/> Site of Service Access Blue New England <input type="checkbox"/> Open Access HDHP	<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
*A PCP must be selected for HMO. A PCP is NOT required for the MAPD plan.			
Primary Care Provider (PCP)* ID # (Find on <a href="http://www.healthtrustnh.org">www.healthtrustnh.org</a> )		PCP* First/Last Name/City/State	

### III. SPOUSE'S/DEPENDENT(S)' TYPE OF COVERAGE AND MEMBERSHIP REQUESTED

Medical Plan Type	Medical Membership	If you have additional dependent(s) to be included on the membership, please complete page 2.
<input type="checkbox"/> High Deductible Health Plan (HDHP) <input type="checkbox"/> HMO* <input type="checkbox"/> HealthTrust Medicare Advantage (MAPD) <input type="checkbox"/> Access Blue HDHP* <input type="checkbox"/> Access Blue New England <input type="checkbox"/> Open Access PPO <input type="checkbox"/> Lumenos Preferred Blue <input type="checkbox"/> Site of Service Access Blue New England <input type="checkbox"/> Open Access HDHP	<input type="checkbox"/> Single <input type="checkbox"/> Two-Person <input type="checkbox"/> Family	
*A PCP must be selected for HMO. A PCP is NOT required for the MAPD plan.		
Primary Care Provider (PCP)* ID # (Find on <a href="http://www.healthtrustnh.org">www.healthtrustnh.org</a> )		PCP* First/Last Name/City/State

### IV. ADDITIONAL COVERAGE INFORMATION

Are you or any of your dependents eligible for or enrolled in Medicare?  Yes  No

Submit a copy of each Covered Individual's Medicare Parts A & B card and indicate below whether coverage is due to end-stage renal disease.

Name _____	Name _____
Is coverage due to end-stage renal disease? <input type="checkbox"/> Yes <input type="checkbox"/> No	Is coverage due to end-stage renal disease? <input type="checkbox"/> Yes <input type="checkbox"/> No

Medical	Dental
Do you currently have medical coverage through another plan (excluding Medicare)? <input type="checkbox"/> Yes <input type="checkbox"/> No	Do you currently have dental coverage through another plan? <input type="checkbox"/> Yes <input type="checkbox"/> No
Are you transferring coverage from another medical carrier? <input type="checkbox"/> Yes <input type="checkbox"/> No	Are you transferring coverage from another dental carrier? <input type="checkbox"/> Yes <input type="checkbox"/> No
Subscriber Name _____	Subscriber Name _____
Medical Insurance Company _____	Dental Insurance Company _____
Effective Date ____/____/____ Termination Date ____/____/____	Effective Date ____/____/____ Termination Date ____/____/____

### V. SIGNATURES for Retiree and Spouse, if applicable

I hereby authorize HealthTrust and my former employer to institute the enrollment(s) indicated on the form. I understand that the effective date of my enrollment will be determined by HealthTrust and my former 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 Retiree's and/or Dependent's 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 former employer immediately when any Dependent no longer meets eligibility requirements of the plan. I understand that HealthTrust is not aware of individual circumstances and available plan options that may impact Retiree choice. I further understand and certify that I have chosen the above-selected plan(s) and that while HealthTrust provides information and answers Retiree questions regarding the different Retiree plan options, I am solely responsible for my choice of plan(s).

Retiree's Signature \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_ Spouse's Signature \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

**VI. EMPLOYER USE ONLY**

Billing Group Name \_\_\_\_\_ Benefits Administrator Signature/Stamp \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

**Retiree**

Medical Group/Carrier Number \_\_\_\_\_ Effective Date of Coverage \_\_\_\_/\_\_\_\_/\_\_\_\_  
 MAPD Group/Carrier Number NH010GRS Effective Date of Coverage \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Dental Group/Carrier Number \_\_\_\_\_ Effective Date of Coverage \_\_\_\_/\_\_\_\_/\_\_\_\_

**Spouse and/or Dependent**

Medical Group/Carrier Number \_\_\_\_\_ Effective Date of Coverage \_\_\_\_/\_\_\_\_/\_\_\_\_  
 MAPD Group/Carrier Number NH010GRS Effective Date of Coverage \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Dental Group/Carrier Number \_\_\_\_\_ Effective Date of Coverage \_\_\_\_/\_\_\_\_/\_\_\_\_

Retiree's Name \_\_\_\_\_ Former Employer Name \_\_\_\_\_

## Additional Dependent(s) Information

Dependent Child Name (First, MI, Last) \_\_\_\_\_ DOB \_\_\_\_/\_\_\_\_/\_\_\_\_ Relation to Retiree \_\_\_\_\_ Gender  M  F  
 Social Security # \_\_\_\_\_  
 Enroll(ed) in  Medical  Dental Primary Care Provider (PCP)\* ID # (Find on [www.healthtrustnh.org](http://www.healthtrustnh.org)) \_\_\_\_\_ PCP\* Name \_\_\_\_\_

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 Social Security # \_\_\_\_\_  
 Enroll(ed) in  Medical  Dental Primary Care Provider (PCP)\* ID # (Find on [www.healthtrustnh.org](http://www.healthtrustnh.org)) \_\_\_\_\_ PCP\* Name \_\_\_\_\_

**If payment for medical and/or dental premium will be deducted from the Retiree's NHRS annuity, a *Retirement Annuity Deduction Authorization for Medical and Dental Benefits form* must also be completed and submitted with this *Retiree and/or Dental Application and Change Form*.**

To be completed by Groups that have elected HealthTrust's retiree billing services			
	MEDICAL		DENTAL
	Retiree	Spouse	
Group Pays:			
Enrollee Pays:			
TOTAL:			