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

If the Retiree is NHRS eligible, a *Retirement Annuity Deduction Authorization for Medical and Dental Benefits* form ("Annuity Form") must also be completed and submitted with this Application.

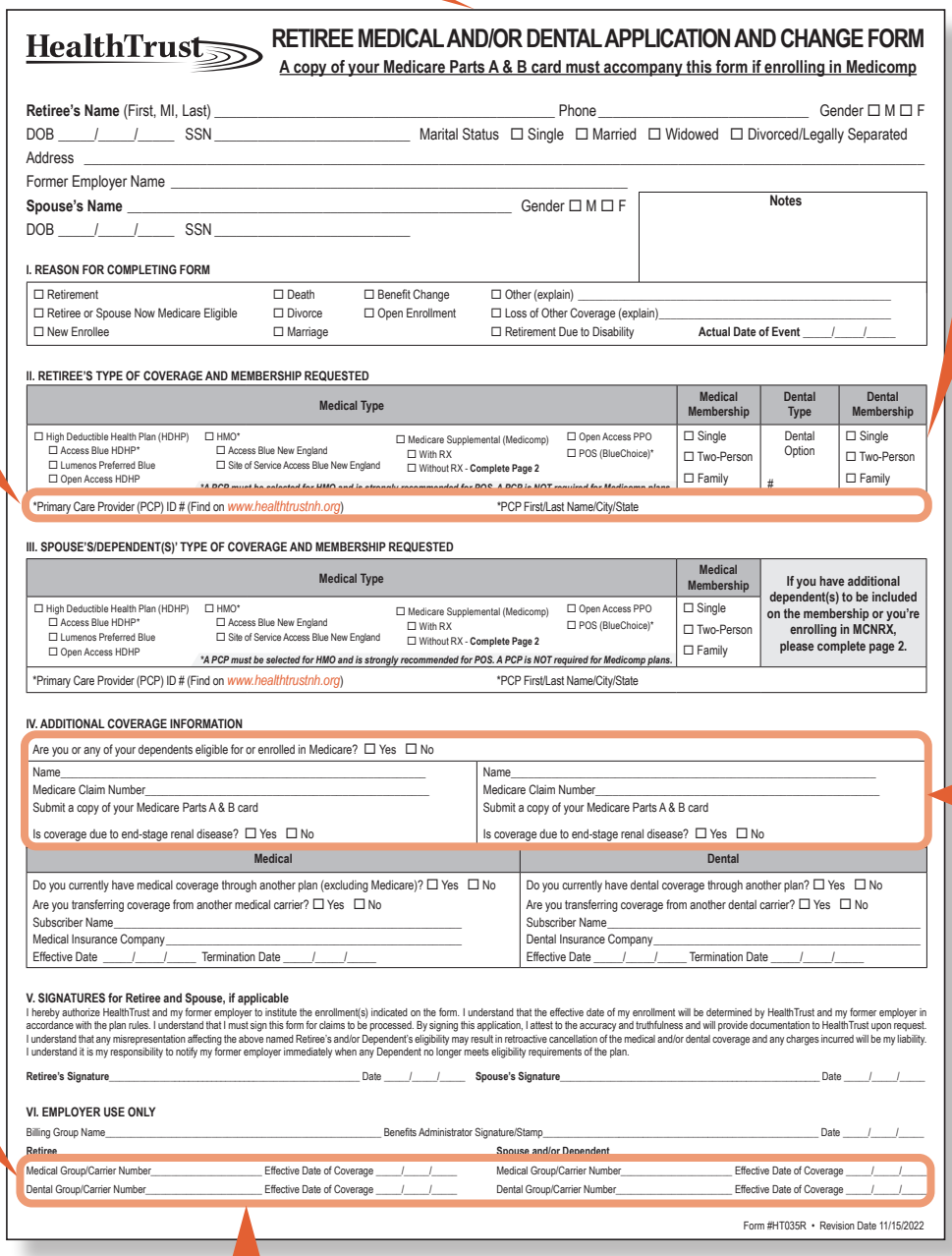
Only one Application form is needed for both a retiree and spouse (if applicable).

Step II:
PCP selection is not required for Medicare Supplemental Plans

Step II:
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.

Step IV:
If the Retiree and/or spouse are Medicare eligible, this section must be completed and a copy of the Medicare Health Insurance card (showing Parts A & B) **must** be submitted with this Application.

Step VI:
Indicate the appropriate Group Carrier Number(s) for the Retiree and spouse (if applicable).



HealthTrust

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 Medicomp

Retiree's Name (First, MI, Last) _____ Phone _____ Gender ☐ M ☐ F
DOB ____/____/____ SSN _____ Marital Status ☐ Single ☐ Married ☐ Widowed ☐ Divorced/Legally Separated
Address _____
Former Employer Name _____
Spouse's Name _____ Gender ☐ M ☐ F
DOB ____/____/____ SSN _____

Notes

I. REASON FOR COMPLETING FORM

☐ Retirement ☐ Retiree or Spouse Now Medicare Eligible ☐ New Enrollee ☐ Death ☐ Divorce ☐ Marriage ☐ Benefit Change ☐ Open Enrollment ☐ Other (explain) _____ ☐ Loss of Other Coverage (explain) _____ ☐ Retirement Due to Disability **Actual Date of Event** ____/____/____

II. RETIREE'S TYPE OF COVERAGE AND MEMBERSHIP REQUESTED

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	☐ Medicare Supplemental (Medicomp) ☐ With RX ☐ Without RX - **Complete Page 2**	☐ 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. A PCP is NOT required for Medicomp plans.

*Primary Care Provider (PCP) ID # (Find on www.healthtrustnh.org) *PCP First/Last Name/City/State

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

Medical Type				Medical Membership	If you have additional dependent(s) to be included on the membership or you're enrolling in MCNRX, please complete page 2.
☐ 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	☐ Medicare Supplemental (Medicomp) ☐ With RX ☐ Without RX - **Complete Page 2**	☐ Open Access PPO ☐ POS (BlueChoice)*	☐ Single ☐ Two-Person ☐ Family	

*A PCP must be selected for HMO and is strongly recommended for POS. A PCP is NOT required for Medicomp plans.

*Primary Care Provider (PCP) ID # (Find on www.healthtrustnh.org) *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

Name _____
Medicare Claim Number _____
Submit a copy of your Medicare Parts A & B card
Is coverage due to end-stage renal disease? ☐ Yes ☐ No

Name _____
Medicare Claim Number _____
Submit a copy of your Medicare Parts A & B card
Is coverage due to end-stage renal disease? ☐ Yes ☐ No

Medical	Dental
Do you currently have medical coverage through another plan (excluding Medicare)? ☐ Yes ☐ No	Do you currently have dental coverage through another plan? ☐ Yes ☐ No
Are you transferring coverage from another medical carrier? ☐ Yes ☐ No	Are you transferring coverage from another dental carrier? ☐ Yes ☐ 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.

Retiree's Signature _____ Date ____/____/____ **Spouse's Signature** _____ Date ____/____/____

VI. EMPLOYER USE ONLY

Billing Group Name _____ Benefits Administrator Signature/Stamp _____ Date ____/____/____

Retiree	Spouse and/or Dependent
Medical Group/Carrier Number _____ Effective Date of Coverage ____/____/____	Medical Group/Carrier Number _____ Effective Date of Coverage ____/____/____
Dental Group/Carrier Number _____ Effective Date of Coverage ____/____/____	Dental Group/Carrier Number _____ Effective Date of Coverage ____/____/____

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Refer to your Group's *Carrier ID Table* for details. The Group Carrier Number must correlate with the Type of Coverage elected in Section II.

HealthTrust

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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) ________ *PCP Name ________________

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) ________ *PCP Name ________________

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) ________ *PCP Name ________________

Medicomp Three without Prescription Drug Coverage (MCNRX) Election

Retiree and/or Spouse Name(s) ________________
(MCNRX Enrollee)

I hereby elect to enroll in the Medicomp Three **without** Prescription Drug Coverage (MCNRX) Plan and am indicating below my intent regarding enrolling in Medicare Part D.

If MCNRX is elected, the applicant **must** check one of these two options as well as sign and date the form.

____ I understand that I also must now enroll in a Medicare Part D prescription drug plan in order to be eligible for a one-time opportunity to later return to my former employer's prescription drug plan for Retirees through HealthTrust. Provided that I enroll in Medicare Part D, I will have a one-time opportunity to return to my former employer's Medicomp Three with Prescription Drug Coverage Plan through HealthTrust within 24 months of this election of the MCNRX plan, but may return only at my former employer's open enrollment or a Medicare open enrollment. **If I do not return within 24 months, I understand that I will forfeit my right to return to prescription drug coverage through my former employer.**

____ I do not intend to also enroll in a Medicare Part D prescription drug plan at this time. **I understand that I am therefore now forfeiting all rights to later return to my former employer's Medicomp Three with Prescription Drug Coverage plan for Retirees through HealthTrust.**

Retiree Signature ________________ Date ___/___/___

Spouse Signature ________________ Date ___/___/___

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:			

Complete this section only if the Retiree and/or Group is to be billed directly for medical and/or dental plan coverage. If payment for coverage is to be remitted by NHRS, do not complete this section; instead, complete a *Retirement Annuity Deduction Authorization for Medical and Dental Benefits* form.

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