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 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 _____

Spouse's Name _____ Gender ☐ M ☐ F

DOB ____/____/____ SSN _____

Notes

I. REASON FOR COMPLETING FORM

☐ Retirement	☐ Death	☐ Benefit Change	☐ Other (explain) _____
☐ Retiree or Spouse Now Medicare Eligible	☐ Divorce	☐ Open Enrollment	☐ Loss of Other Coverage (explain)_____
☐ New Enrollee	☐ Marriage		☐ 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
☐ 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 ☐ HealthTrust Medicare Advantage (MAPD) ☐ Open Access PPO ☐ POS (BlueChoice)* ***A PCP must be selected for HMO and is strongly recommended for POS. A PCP is NOT required for the MAPD plan.***	☐ Single ☐ Two-Person ☐ Family	Dental Option #_____	☐ Single ☐ Two-Person ☐ Family
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 Plan Type	Medical 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 ☐ HealthTrust Medicare Advantage (MAPD) ☐ Open Access PPO ☐ POS (BlueChoice)* ***A PCP must be selected for HMO and is strongly recommended for POS. A PCP is NOT required for the MAPD plan.***	☐ Single ☐ Two-Person ☐ Family	**If you have additional dependent(s) to be included on the membership, please complete page 2.**
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

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? ☐ Yes ☐ No	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 Are you transferring coverage from another medical carrier? ☐ Yes ☐ No Subscriber Name_____ Medical Insurance Company_____ Effective Date ____/____/____ Termination Date ____/____/____	Do you currently have dental coverage through another plan? ☐ Yes ☐ No Are you transferring coverage from another dental carrier? ☐ Yes ☐ No Subscriber Name_____ Dental Insurance Company_____ 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*) _____ 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 _____

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:			