

WELCOME TO HEALTHTRUST

HealthTrust is a non-profit membership organization whose sole purpose is to provide New Hampshire school, municipal and county employees with quality benefit packages.

Please use this form to enroll in or change your dental coverage. Be sure to complete this entire form and retain the PINK copy to serve as your temporary ID card. If you only need to change your mailing address, do not complete this form; instead, call HealthTrust's Member Relations Department at 1-800-527-5001 and notify your employer.

BE SURE TO FILL OUT EACH SECTION COMPLETELY. Include information on all your covered family members at initial enrollment and when making changes. Failure to complete each section in full could delay the start of coverage.

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	<p>SUBSCRIBER (EMPLOYEE) INFORMATION</p> <p>Complete this section with your personal information, using your full legal name. Select the type of HealthTrust-sponsored dental coverage you are requesting and the membership type. Please limit your selection to only those coverages offered by your employer and for which you are eligible.</p>
STEP 2	<p>REASON FOR COMPLETING FORM</p> <p>Use this section to indicate the reason(s) for completing form. If you are a current HealthTrust subscriber 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.</p>
STEP 3	<p>SUBSCRIBER AND DEPENDENT INFORMATION</p> <p>Complete this section as your membership should appear at HealthTrust. If you need additional space, use the <i>Additional Dependent Information</i> section on the last page of this form. If one or more dependents resides at a different address, complete the <i>Dependents with a Different Mailing Address</i> section on the last page of this form.</p> <ul style="list-style-type: none"> • If you are enrolling a dependent(s) age 19 or older who is a full-time student, complete the <i>Full-Time Student Certification</i> section on the last page of this form. Your dependent will not be added to your coverage until the completed form has been received by HealthTrust. • If you are enrolling a dependent(s) age 19 or older who is disabled, complete a <i>Request for Certification for a Mentally or Physically Incapacitated Dependent Child</i> form available through your employer. Your dependent will not be added to your coverage until approval of incapacitated status has been received at HealthTrust.
STEP 4	<p>OTHER DENTAL INSURANCE COVERAGE INFORMATION</p> <p>Complete this section if you or a covered family member will have other coverage along with this plan or are transferring from another group dental plan. If you choose two-person coverage for yourself and your child, you must include proof of your spouse's coverage.</p>
STEP 5	<p>SUBSCRIBER SIGNATURE</p> <p>Sign and date this form; return completed form to your employer.</p>
STEP 6	<p>EMPLOYER USE ONLY</p> <p>Employer must complete this section and forward to HealthTrust for processing. HealthTrust's address is: PO Box 617, Concord, NH 03302</p>

SUBSCRIBER (EMPLOYEE) INFORMATION

STEP 1	Last Name		First Name		MI	STEP 2	REASON FOR COMPLETING FORM		HealthTrust Office Use Only
	Social Security #		Telephone ()						
	Mailing Address								
	City		State	Zip	Employer Name				
	Is your position covered by a collective bargaining agreement? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, check the appropriate category: <input type="checkbox"/> Teacher <input type="checkbox"/> Police <input type="checkbox"/> Fire <input type="checkbox"/> Public Works <input type="checkbox"/> Other								
	Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Married <input type="checkbox"/> Legally Separated <input type="checkbox"/> Widowed		TYPE OF COVERAGE AND MEMBERSHIP REQUESTED (check)						
Dental Type			Dental Membership						
Dental Option # _____			<input type="checkbox"/> Single <input type="checkbox"/> Two-Person <input type="checkbox"/> Family						
		Dependent Name _____				<input type="checkbox"/> Retirement <input type="checkbox"/> Election of COBRA Coverage <input type="checkbox"/> Spouse's Employment Change Actual Date of Event _____			

SUBSCRIBER AND DEPENDENT INFORMATION (Complete this section as your membership should appear)

STEP 3	NAME (First, MI, Last)	Date of Birth Month / Day / Year	Relation to Subscriber	Gender M/F	Student Over 19	Disabled
	Employee Name	___/___/___	Self			
	Spouse Name	___/___/___	Spouse			
	Dependent Name**	___/___/___			<input type="checkbox"/>	<input type="checkbox"/>
	Dependent Name**	___/___/___			<input type="checkbox"/>	<input type="checkbox"/>
	Dependent Name**	___/___/___			<input type="checkbox"/>	<input type="checkbox"/>

**If your dependent(s) is/are age 19 or older, complete the form attached to the back of this application.

OTHER DENTAL INSURANCE COVERAGE INFORMATION

STEP 4	Do you or your family have dental coverage through another group or employer? <input type="checkbox"/> Yes <input type="checkbox"/> No	Name of Insurance Company	
	Are you or another dependent transferring coverage from another dental carrier? <input type="checkbox"/> Yes <input type="checkbox"/> No	Policy Number	
	Member Name	Effective Date	Termination Date

SUBSCRIBER SIGNATURE

STEP 5	I hereby authorize HealthTrust and my employer to institute the action(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 of this information and will provide documentation to HealthTrust upon request.	
	Subscriber Signature _____	Date ___/___/___

EMPLOYER USE ONLY

STEP 6	Date of Hire ___/___/___	Date of Rehire ___/___/___	<input type="checkbox"/> Full-Time	<input type="checkbox"/> Part-Time Number of Hours Weekly _____	<input type="checkbox"/> COBRA	<input type="checkbox"/> Retiree
	Eligibility Organization Name			Employee Job Title		
	Dental Group/Carrier Number		Effective Date of Coverage ___/___/___		Benefits Administrator Signature/Stamp	

Subscriber Name _____ **Employer Name** _____

A. ADDITIONAL DEPENDENT INFORMATION – If you are enrolling more than three dependents, please complete the information below.

NAME (First, MI, Last)	Date of Birth Month / Day / Year	Relation to Subscriber	Gender M/F	Student Over 19	Disabled
Dependent Name**	___/___/___			<input type="checkbox"/>	<input type="checkbox"/>
Dependent Name**	___/___/___			<input type="checkbox"/>	<input type="checkbox"/>
Dependent Name**	___/___/___			<input type="checkbox"/>	<input type="checkbox"/>

**If your dependent(s) is/are age 19 or older, complete the Full-Time Student Certification section below.

B. DEPENDENTS WITH A DIFFERENT MAILING ADDRESS – If one or more dependents resides at an address different from yours, include that address below, unless he or she is a full-time student living at school.

Dependent's Name	Street / P.O. Box	City	State	Zip Code

C. FULL-TIME STUDENT CERTIFICATION

HealthTrust will provide coverage for qualified dependents between the ages of 19 and 25 if the dependent is an unmarried, full-time student enrolled in a minimum of 12 credit hours per semester at an accredited school. We will verify each dependent's eligibility annually when the dependent is between the ages of 19 and 25.

Please complete the following information to verify that the person(s) named below is/are currently enrolled as a full-time student(s). We reserve the right to contact the dependent's school directly and/or to request documentation for periodic verification.

Student Name	Name of Accredited School	Number of Credit Hours	Date Current Semester Began
			___/___/___
			___/___/___
			___/___/___

Subscriber Signature _____ **Date** ___/___/___