



DENTAL APPLICATION AND CHANGE FORM

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 needed. If you only need to change your mailing address, do not complete this form; instead, call HealthTrust's Enrollee Services Department at 800.527.5001 **and** notify your employer.

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.

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	ENROLLEE (EMPLOYEE) INFORMATION 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.
STEP 2	REASON FOR COMPLETING FORM Use this section to indicate the reason(s) for completing form. If you are 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 <i>Additional Dependent Information</i> section on the last page of this form. • If you are enrolling a dependent(s) age 26 or older who is disabled, complete a <i>Certification for a Mentally or Physically Disabled Child Over Maximum Age</i> form, available through your employer or at www.healthtrustnh.org . Your dependent will not be added to your coverage until approval of incapacitated status has been received by HealthTrust.
STEP 4	OTHER DENTAL 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 dental plan. If you are married and elect two-person coverage for yourself and your child, you must include proof of your spouse's coverage.
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 forward to HealthTrust for processing at: PO Box 617, Concord, NH 03302



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

DENTAL APPLICATION AND CHANGE FORM

ENROLLEE (EMPLOYEE) INFORMATION

S T E P 1	Last Name	First Name	MI		
	Social Security #	Telephone	Email		
	Mailing Address	City	State	Zip	
	Email	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		TYPE OF COVERAGE AND MEMBERSHIP REQUESTED (check)		
	Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced/Legally Separated		Dental Type	Dental Membership	
	Dental Option # _____	<input type="checkbox"/> Single <input type="checkbox"/> Two-Person <input type="checkbox"/> Family			

S T E P 2	REASON FOR COMPLETING FORM	
	<input type="checkbox"/> New Enrollee <input type="checkbox"/> Benefit Change <input type="checkbox"/> Open Enrollment <input type="checkbox"/> Name Change <input type="checkbox"/> Marriage <input type="checkbox"/> Birth/Adoption <input type="checkbox"/> Death <input type="checkbox"/> Divorce/Legal Separation	<input type="checkbox"/> Dependent No Longer Eligible <hr/> Dependent Name <input type="checkbox"/> Retirement <input type="checkbox"/> Retiree or Spouse Now Medicare Eligible <input type="checkbox"/> Loss of Other Coverage (explain) <hr/> <input type="checkbox"/> Election of COBRA Coverage <input type="checkbox"/> Other (explain)
	Actual Date of Event _____	

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

S T E P 3	NAME (First, MI, Last)	Date of Birth Month/Day/Year	Relation to Enrollee	Gender
	Employee Name	__/__/__	Self	<input type="checkbox"/> Male <input type="checkbox"/> Female
	Spouse Name	__/__/__	Spouse/Civil Union Partner	<input type="checkbox"/> Male <input type="checkbox"/> Female
	Spouse Email			
	Dependent Name**	__/__/__		<input type="checkbox"/> Male <input type="checkbox"/> Female
	Dependent Name**	__/__/__		<input type="checkbox"/> Male <input type="checkbox"/> Female
	Dependent Name**	__/__/__		<input type="checkbox"/> Male <input type="checkbox"/> Female

HealthTrust Office Use Only

**If you are enrolling a dependent(s) 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 DENTAL INSURANCE COVERAGE INFORMATION

S T E P 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

ENROLLEE SIGNATURE

S T E P 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 will result in retroactive cancellation of the 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

S T E P 6	Date of Hire __/__/__	Date of Rehire __/__/__	<input type="checkbox"/> Full-Time	<input type="checkbox"/> Part-Time to 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		Date __/__/__



Please complete section A, as necessary, and return with your application.

Enrollee 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 Enrollee	Gender
Dependent Name**	___/___/___		<input type="checkbox"/> Male <input type="checkbox"/> Female
Dependent Name**	___/___/___		<input type="checkbox"/> Male <input type="checkbox"/> Female
Dependent Name**	___/___/___		<input type="checkbox"/> Male <input type="checkbox"/> Female
Dependent Name**	___/___/___		<input type="checkbox"/> Male <input type="checkbox"/> Female
Dependent Name**	___/___/___		<input type="checkbox"/> Male <input type="checkbox"/> Female

**If you are enrolling a dependent(s) 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 ___/___/___