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 generally 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 *Additional Dependent(s) Information* section on the last page of this form. • If you are enrolling a dependent child 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.* **Your dependent child 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 choose to cover some, but not all of your eligible dependents, proof of other group coverage for those dependents you are not covering may be required.
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; email to: enrolleeservices@healthtrustnh.org; or fax to: 603.226.2988

DENTAL APPLICATION AND CHANGE FORM

ENROLLEE (EMPLOYEE) INFORMATION

STEP 1

Last Name	First Name		MI
Mailing Address	City	State	Zip
Telephone	Email		
Social Security #	Employer Name		
Is your position covered by a collective bargaining agreement? ☐ Yes ☐ No If yes, check the appropriate category: ☐ Teacher ☐ Police ☐ Fire ☐ Public Works ☐ Other	**TYPE OF COVERAGE AND MEMBERSHIP REQUESTED (check)**		
Marital Status ☐ Single ☐ Married ☐ Other _____ ☐ Widowed ☐ Divorced/Legally Separated	**Dental Type** Dental Option #_____	**Dental Membership** ☐ Single ☐ Two-Person ☐ Family	

STEP 2

REASON FOR COMPLETING FORM

- ☐ New Enrollee
- ☐ Benefit Change
- ☐ Open Enrollment
- ☐ Name Change
- ☐ Marriage
- ☐ Birth/Adoption
- ☐ Death
- ☐ Divorce/Legal Separation
- ☐ Dependent No Longer Eligible

Dependent Name _____

- ☐ Retirement
- ☐ Retiree or Spouse Now Medicare Eligible
- ☐ Loss of Other Coverage (explain) _____
- ☐ Election of COBRA Coverage
- ☐ Other (explain) _____

Actual Date of Event _____

ENROLLEE 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 Enrollee	Gender
Employee Name		Self	☐ Male ☐ Female
Spouse Name		Spouse	☐ Male ☐ Female
	Spouse Email		
Dependent Child Name**			☐ Male ☐ Female
Dependent Child Name**			☐ Male ☐ Female
Dependent Child Name**			☐ Male ☐ Female

HealthTrust Office Use Only

****If you are enrolling a dependent child 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

STEP 4

Do you or your family have dental coverage through another group or employer? ☐ Yes ☐ No	Name of Insurance Company	
Are you or another dependent transferring coverage from another dental carrier? ☐ Yes ☐ No	Policy Number	
Member Name	Effective Date	Termination Date

ENROLLEE SIGNATURE

STEP 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 may 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

STEP 6

Date of Hire	Date of Rehire	☐ Full-Time	☐ Part-Time to Full-Time Date	☐ Part-Time Number of Hours Weekly_____	☐ COBRA	☐ Retiree
Eligibility Organization Name				Employee Job Title		
Dental Group/Carrier Number		Effective Date of Coverage		Benefits Administrator Signature/Stamp		Date

HealthTrust

White - HealthTrust Yellow - Employer Pink - Employee

Form #HT037
Revision Date 9/15

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

Enrollee Name _____ **Employer Name** _____

A. ADDITIONAL DEPENDENT(S) INFORMATION – If you are enrolling more than three dependent children, please complete the information below.

NAME (First, MI, Last)	Date of Birth Month/Day/Year	Relation to Enrollee	Gender
Dependent Child Name**			☐ Male ☐ Female
Dependent Child Name**			☐ Male ☐ Female
Dependent Child Name**			☐ Male ☐ Female
Dependent Child Name**			☐ Male ☐ Female
Dependent Child Name**			☐ Male ☐ Female

****If you are enrolling a dependent child 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