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 _____

Email _____

Former Employer Name_____

Spouse's Name _____ Gender ❒ M ❒ F

DOB _____/_____/_____ SSN_____

Email _____

HealthTrust Office Use ONLY

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 ❒ COBRA Coverage Election ❒ 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
❒ HMO* ❒ Access Blue New England* ❒ Site of Service Access Blue New England* ❒ POS (BlueChoice)* ❒ HDHP (Lumenos) ❒ Indemnity (JY, JW, or Comp) ❒ PPO (Preferred Blue) ❒ Medicare Supplemental (Medicomp) ❒ With RX ❒ Without RX - **Complete Last Page** Benefit String: _____	❒ Single ❒ Two-Person ❒ Family	Dental Option #_____	❒ Single ❒ Two-Person ❒ Family

*Primary Care Provider (PCP) ID # *PCP Name

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

Medical Type	Medical Membership	
❒ HMO* ❒ Access Blue New England* ❒ Site of Service Access Blue New England* ❒ POS (BlueChoice)* ❒ HDHP (Lumenos) ❒ Indemnity (JY, JW, or Comp) ❒ PPO (Preferred Blue) ❒ Medicare Supplemental (Medicomp) ❒ With RX ❒ Without RX - **Complete Last Page** Benefit String: _____	❒ Single ❒ Two-Person ❒ Family	**If you have additional dependent(s) to be included on the membership or you're enrolling in MCNRX, please complete page 2.**

*Primary Care Provider (PCP) ID # *PCP Name

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 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.

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

VI. EMPLOYER USE ONLY

Eligibility Organization Name_____ Benefits Administrator Signature/Stamp_____ Date _____/_____/_____

Retiree	**Spouse and/or Dependent**
Medical Group/Carrier Number_____ Eff. Date of Coverage ____/____/____	Medical Group/Carrier Number_____ Eff. Date of Coverage ____/____/____
Dental Group/Carrier Number_____ Eff. Date of Coverage ____/____/____	Dental Group/Carrier Number_____ Eff. 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 # _____ *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 # _____ *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 # _____ *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.

____ 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:			