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

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****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

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