



MEDICAL AND/OR DENTAL APPLICATION AND CHANGE FORM

Please use this form to enroll in or change your medical and/or 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 New Hampshire Local Government Center (LGC) HealthTrust's Member 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.

PRIMARY CARE PROVIDER (PCP) SELECTION

When you enroll in a BlueChoice® or Matthew Thornton BlueSM medical plan, each member of your family must choose their own PCP to coordinate medical care. Your PCP can be a family or general practitioner, an internist, or a pediatrician (for children). A Provider Directory can be accessed on-line at www.nhlgc.org by clicking on "HealthTrust Online." Should you decide to change your PCP after initially enrolling with LGC HealthTrust, do not fill out this form. Instead, call the Customer Service number on your medical ID card.

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	SUBSCRIBER (EMPLOYEE) INFORMATION Complete this section with your personal information, using your full legal name. Select the type of LGC HealthTrust-sponsored medical and/or dental coverage you are requesting and the membership type for each. If you are applying for the Medicare Supplemental benefit, you must include a copy of your Medicare card showing Parts A & B. 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 LGC HealthTrust subscriber making a change to your existing membership, you must include the actual date of event. Please see your employer or call LGC HealthTrust to obtain additional forms that are required for divorce/legal separation or retirement.
STEP 3	SUBSCRIBER AND DEPENDENT INFORMATION Complete this section as your membership should appear at LGC 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. <ul style="list-style-type: none"> • If you are enrolling a dependent(s) age 19 or older, complete a <i>Dependent Child Certification Form</i> for each child, available through your employer or at www.nhlgc.org. Your dependent will not be added to your coverage until the completed form has been received by LGC 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 or at www.nhlgc.org. Your dependent will not be added to your coverage until approval of incapacitated status has been received by LGC HealthTrust. • If your LGC HealthTrust-sponsored medical plan requires a PCP, you must provide a PCP ID number (including all characters) for you and each of your covered dependents; indicate if you are a current patient.
STEP 4	OTHER 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 medical or dental plan. If you choose two-person coverage for yourself and your child, you must include proof of your spouse's coverage.
STEP 5	SUBSCRIBER SIGNATURE Sign and date this form, return completed form to your employer.
STEP 6	EMPLOYER USE ONLY Employer must complete this section and forward to LGC HealthTrust for processing. LGC HealthTrust's address is: PO Box 617, Concord, NH 03302

MEDICAL AND/OR DENTAL APPLICATION AND CHANGE FORM

SUBSCRIBER (EMPLOYEE) INFORMATION

S T E P 1	Last Name		First Name		MI
	Mailing Address		City	State	Zip
	Telephone		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		Medical Type		Medical Membership	Dental Type
		<input type="checkbox"/> Indemnity (JY, JW or Comp) <input type="checkbox"/> Medicare Supplement <input type="checkbox"/> HMO (Matthew Thornton) ↓ <input type="checkbox"/> POS (BlueChoice) <input type="checkbox"/> With RX <input type="checkbox"/> PPO <input type="checkbox"/> Without RX <input type="checkbox"/> Health Savings Account (HSA)		<input type="checkbox"/> Single <input type="checkbox"/> Two-Person <input type="checkbox"/> Family	Dental Option # _____

S T E P 2	REASON FOR COMPLETING FORM	
	<input type="checkbox"/> New Subscriber <input type="checkbox"/> Benefit Change/Transfer <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 Dependent Name _____ <input type="checkbox"/> Retirement <input type="checkbox"/> Retiree or Spouse Now Medicare Eligible <input type="checkbox"/> Loss of Other Coverage (explain) _____ <input type="checkbox"/> Election of COBRA Coverage <input type="checkbox"/> Other (explain) _____
	Actual Date of Event _____	
	LGC HealthTrust Office Use Only	

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

S T E P 3	NAME (First, MI, Last)	Social Security #	Date of Birth Month/Day/Year	Relation to Subscriber	Gender	Enroll(ed) in		Primary Care Provider (for HMO or POS Medical Type)		Current Patient
						Medical	Dental	PCP #	First/Last Name	
	Employee Name		___/___/___	Self	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/> Y <input type="checkbox"/> N
	Spouse Name		___/___/___	Spouse	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/> Y <input type="checkbox"/> N
	Dependent Name**	Not Applicable	___/___/___		<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/> Y <input type="checkbox"/> N
	Dependent Name**		___/___/___		<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/> Y <input type="checkbox"/> N
Dependent Name**	___/___/___			<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/> Y <input type="checkbox"/> N	

**If your dependent(s) is/are age 19 or older, complete a *Dependent Child Certification Form*, available through your employer or at www.nhlgc.org. If you are enrolling a dependent(s) age 19 or older who is disabled, complete a *Request for Certification for a Mentally or Physically Incapacitated Dependent Child* form available through your employer or at www.nhlgc.org.

OTHER MEDICAL INSURANCE COVERAGE INFORMATION

OTHER DENTAL INSURANCE COVERAGE INFORMATION

S T E P 4	Do you or your family have medical coverage through another group or employer? <input type="checkbox"/> Y <input type="checkbox"/> N				Do you or your family have dental coverage through another group or employer? <input type="checkbox"/> Y <input type="checkbox"/> N			
	Are you or another dependent transferring coverage from another medical carrier? <input type="checkbox"/> Y <input type="checkbox"/> N				Are you or another dependent transferring coverage from another dental carrier? <input type="checkbox"/> Y <input type="checkbox"/> N			
	Member Name		Name of Insurance Company		Member Name		Name of Insurance Company	
	Policy Number		Effective Date		Termination Date		Termination Date	
	Are you or any of your dependents eligible for Medicare? <input type="checkbox"/> Y <input type="checkbox"/> N				Medicare Claim Number _____			
Part A (Hospital) Effective Date ___/___/___		Part B (Medical) Effective Date ___/___/___		Medicare Claim Number _____		Is coverage due to end-stage renal disease? <input type="checkbox"/> Y <input type="checkbox"/> N		

SUBSCRIBER SIGNATURE

S T E P 5	I hereby authorize LGC 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 LGC 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 LGC HealthTrust upon request. I understand that any misrepresentation affecting the above named Subscriber's and/or Dependents' eligibility will 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 employer immediately when any Dependent no longer meets eligibility requirements of the plan.	
	Subscriber 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			
	Medical Group/Carrier Number				Effective Date of Coverage ___/___/___			
	Dental Group/Carrier Number				Effective Date of Coverage ___/___/___			
						Benefits Administrator Signature/Stamp		
						Date ___/___/___		

Please complete sections A or B, as necessary, and return with your application.

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	Enroll(ed) in		Primary Care Provider (for HMO or POS Medical Type)		Current Patient
				Medical	Dental	PCP #	First/Last Name	
Dependent Name**	___/___/___		<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/> Y <input type="checkbox"/> N
Dependent Name**	___/___/___		<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/> Y <input type="checkbox"/> N
Dependent Name**	___/___/___		<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/> Y <input type="checkbox"/> N
Dependent Name**	___/___/___		<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/> Y <input type="checkbox"/> N
Dependent Name**	___/___/___		<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/> Y <input type="checkbox"/> N
Dependent Name**	___/___/___		<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/> Y <input type="checkbox"/> N

**If your dependent(s) is/are age 19 or older, complete a *Dependent Child Certification Form*, available through your employer or at www.nhlgc.org. If you are enrolling a dependent(s) age 19 or older who is disabled, complete a *Request for Certification for a Mentally or Physically Incapacitated Dependent Child* form available through your employer or at www.nhlgc.org.

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

Subscriber Signature _____ Date ___/___/___