LGC
NEW HAMPSHIRE
Local Government Center

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 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 covered 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	**SUBSCRIBER (EMPLOYEE) INFORMATION** Complete this section with your personal information, using your full legal name. Select the type of LGC 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 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 *Additional Dependent Information* section on the last page of this form. If one or more dependents resides at a different address, complete the *Dependents with a Different Mailing Address* section on the last page of this form. • If you are enrolling a dependent(s) age 19 or older, complete a *Dependent Child Certification Form* 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 *Request for Certification for a Mentally or Physically Incapacitated Dependent Child* 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.**
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 two-person coverage for yourself and your child, you must include proof or 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

DENTAL APPLICATION AND CHANGE FORM

SUBSCRIBER (EMPLOYEE) INFORMATION

STEP 1

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

STEP 2

REASON FOR COMPLETING FORM

❑ Benefit Change/Transfer
❑ Open Enrollment
❑ Name Change
❑ Marriage
❑ Civil Union
❑ Birth/Adoption
❑ Death
❑ Divorce/Legal Separation
❑ Civil Union Dissolution
❑ 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 _____

SUBSCRIBER 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 Subscriber	Gender
Employee Name	___/___/___	Self	❑ Male ❑ Female
Spouse/Civil Union Partner Name	___/___/___	Spouse/Civil Union Partner	❑ Male ❑ Female
Dependent Name**	___/___/___		❑ Male ❑ Female
Dependent Name**	___/___/___		❑ Male ❑ Female
Dependent Name**	___/___/___		❑ Male ❑ Female

LGC HealthTrust Office Use Only

****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 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

SUBSCRIBER SIGNATURE

STEP 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 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

STEP 6

Date of Hire ___/___/___	Date of Rehire ___/___/___	❑ Full-Time	❑ Part-Time to Full-Time	❑ 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 ___/___/___

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
Dependent Name**	____/____/____		❑ Male ❑ Female
Dependent Name**	____/____/____		❑ Male ❑ Female
Dependent Name**	____/____/____		❑ Male ❑ Female
Dependent Name**	____/____/____		❑ Male ❑ Female
Dependent Name**	____/____/____		❑ Male ❑ Female

**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 ____/____/____