MRSD SAU 93
600 OLD HOMESTEAD HIGHWAY
SWANZEY, NEW HAMPSHIRE 03446

Name and/or Address Change Form

If you have an address or name change, please fill out the forms following this cover letter.

Employee name____

Building ____

Effective Date ____

(Complete below ONLY what is applicable)

MARRIAGE/DIVORCE

- **Update your W-4 for payroll if needed.**
- **If you need to change the Medical Membership (Single, Two-person, Family) Use the Medical/Dental Application and Change Form.**
  NOTE: If you also are using CVS/Caremark's mail service program for prescription drug orders, you will need to contact CVS/Caremark Customer Care at 888-726-1631 and notify them of your address change.
- **Make sure you sign and date all the forms that would apply to your current benefit situation, as well as the SAU Name & Address Change Form. Return them to the SAU Office Attention Personnel Coordinator.**

New Name ____

Reason for change ______marriage _____ Other

- Your Marriage Certificate or Divorce Decree is required with this paperwork within 30 days of the event.
- (To change beneficiaries you can go online https://www.mrsd.org/Page/321 and select Beneficiary Forms.)

ADDRESS CHANGE

Street ____

Town ____

State ________________ Zip Code ___________

Phone ____

EMPLOYEE'S SIGNATURE _____________________________________ DATE __________

SAU Use Only - Please initial steps completed.

____ Infinite Visions

____ Anthem

____ Notify school Admin/Admin asst.

____ I9 (marriage/divorce)

____ NH Retirement

____ Help Desk Ticket (Alma)

____ Medical/Dental

____ Frontline

____ Accounts Payable/Payroll/PC

New Hampshire Retirement System
54 Regional Drive, Concord, NH 03301
Phone: (603) 410-3500 - Fax: (603) 410-3501
Website: www.nhrs.org - Email: info@nhrs.org

PERSONAL INFORMATION CHANGE FORM

Please Complete the Applicable Areas:

SECTION I – CHANGE OF ADDRESS	
Name (if retired, as it appears on check or non-negotiable)	Social Security Number (last four digits)
Are you currently receiving an NHRS monthly benefit? ☐ Yes ☐ No	Employer's Name (if you are currently employed)
Old Address	New Address
City, State, Zip	City, State, Zip
Old Telephone	New Telephone
Old Email Address	New Email Address
For Email changes: ☐ Also update this address for *NHRS Email Updates* ☐ Sign me up for *NHRS Email Updates* Note: *My Account* users must log in to their personal account and manually change their email address for account authentication purposes.	

SECTION II – CHANGE OF NAME	
Please provide proof of name change (marriage certificate, legal document, etc.)	
Former Name	
Current Name	Effective Date

SECTION III – SIGNATURE	
Please provide your signature to authorize the requested change.	
Printed Name	
Signature	Date

SECTION IV – FOR OFFICE USE ONLY	
ANNUITANT	**ACTIVE**
Retirement #	By
Employer #	Date
By	
Date	

The New Hampshire Retirement System (NHRS) is governed by New Hampshire RSA 100-A, rules, regulations, and Federal laws including the Internal Revenue Code. NHRS also implements policies adopted by the Board of Trustees. These laws, rules, regulations, and policies are subject to change. Even though the goal of NHRS is to provide information that is current, correct, and complete, NHRS does not make any representation or warranty as to the current applicability, accuracy, or completeness of any information provided. The information herein is intended to provide general information only, and should not be construed as a legal opinion or as legal advice. Members are encouraged to address specific questions regarding NHRS with an NHRS representative. In the event of any conflict between the information herein and the laws, rules, and regulations which govern NHRS, the laws, rules, and regulations shall prevail.

INFORMATION UPDATE/CORRECTION FORM

DATE: ___________________

ENROLLEE INFORMATION:

NAME: ____ DATE OF BIRTH: ___________________________

SIGNATURE: ____

❑ Check here if you are a participant in a Flexible Spending Account (FSA) plan offered through HealthTrust.

ACTION REQUESTED:

❑ **Change/Update Address**	**New Address:** Street: ______________________________ City: __________________ State: ________ Zip: __________ Phone:(____)__________________ Email: ______________________
❑ **Correct DOB**	**Name of Individual:** ______________________________ Relationship to Enrollee: ❑ Self ❑ Spouse ❑ Child Correct DOB: _____/_____/_____
❑ **Correct Name Spelling**	**Incorrect Spelling:** ______________________________ Relationship to Enrollee: ❑ Self ❑ Spouse ❑ Child Correct Spelling: ______________________________
❑ **Change Name***	**Name of Individual:** ______________________________ Relationship to Enrollee: ❑ Self ❑ Spouse ❑ Child New Name: ______________________________ Reason for Name Change: ❑ Marriage ❑ Divorce ❑ Other________________ *Please Explain*
❑ **Gender Change**	**Name of Individual:** ______________________________ Relationship to Enrollee: ❑ Self ❑ Spouse ❑ Child Gender Change: From: ❑ Male ❑ Female To: ❑ Male ❑ Female

*HealthTrust may request additional documentation.

EMPLOYER INFORMATION:

BENEFITS ADMINISTRATOR: ___________________________________ GROUP NAME: ___________________________

SIGNATURE: ____ PHONE NUMBER: _______________________

Please Note: If you are using CVS Caremark®'s mail service program, you will need to update/correct your prescription drug mail order address directly with CVS Caremark by calling **888.726.1631** or visiting ***www.caremark.com*** and entering your login ID and password.

Please submit this form to HealthTrust using one of the following methods.

Mail: HealthTrust, PO Box 617, Concord, NH 03302-0617
Email: enrolleeservices@healthtrustnh.org
Secure Enrollee Portal (SEP) Message Center:
Log in to your SEP account and click Message Center.

Complete highlighted sections only

New Hampshire Employee Enrollment

Read and complete all of this form. If you need more space, attach a separate sheet of paper and sign and date. Please use 4 digits for years (e.g. 2016, not 16).

EMPLOYER USE ONLY

Group no. AL00005013	Division no.	Class	Requested effective date (MM/DD/YYYY)

Section 1: REASON FOR ENROLLMENT

Event date (MM/DD/YYYY)

☐ New enrollment ☐ Change of class ☐ Family addition ☐ Change of status
☐ Late enrollment ☐ Reinstatement ☐ Change of name/address ☐ Change of coverage
☐ Waive coverages (complete sections 1, 2, 6 and 10) ☐ Portability (complete sections 1, 2 and 7)
☐ COBRA – effective date: ☐ Open enrollment

Section 2: ENROLLEE INFORMATION

Identification number (Social security #)	Marital status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed	Sex ☐ M ☐ F	Date of birth (MM/DD/YYYY)

Last name	First name	M.I.

Street address	City	State	ZIP code	County	Municipality

Are you actively at work? ☐ Yes ☐ No	If no, state reason	Are you retired? ☐ Yes ☐ No	State of birth

Employer/Group name	Occupation	Date of hire as full-time (MM/DD/YYYY)
Monadnock Regional School District SAU 93		

Hours worked per week for this employer	Current income: ___ ☐ Hour ☐ Week ☐ Month ☐ Year	Income reported on: ☐ W-2 ☐ 1099 ☐ Other: ___	Height	Weight

Home phone no. ( )	Work phone no. ( )	Fax no. ( )	Email address

Section 3: DEPENDENT DETAILS — Complete all details for individuals enrolling for this coverage; list names of all dependents.

Please note: If any dependent has a different address, please write the dependent's name, relationship to the employee, and address on a separate sheet and attach to this enrollment.

Last name, first name, M.I.	Sex	Date of birth (MM/DD/YYYY)	Age	Relationship	Height	Weight	State of birth
	☐ M ☐ F						
	☐ M ☐ F						
	☐ M ☐ F						
	☐ M ☐ F						
	☐ M ☐ F						

Si usted necesita ayuda en Español para entender este documento, puede solicitarlo sin ningun costo adicional llamando al número de servicio al cliente que se encuentra en este documento.

Life and Disability products underwritten by Anthem Life Insurance Company, an independent licensee of the Blue Cross and Blue Shield Association. Anthem is a registered trademark of Anthem Insurance Companies, Inc.

Section 4: STATUS CHANGE

Reason for change: ☐ Marriage ☐ Divorce ☐ Spouse deceased ☐ Birth/adoption ☐ Termination of employment	
☐ Change name to	Date change occurred (MM/DD/YYYY)
☐ Change address to	Date change occurred (MM/DD/YYYY)
☐ Add/delete dependent (name of dependent)	Date of birth/adoption (MM/DD/YYYY)
☐ Change coverage amount Current benefit amount: $ ____________ Change benefit amount to: $ ____________	Date change occurred (MM/DD/YYYY)
☐ Change life class to	Date change occurred (MM/DD/YYYY)
☐ Other change (explain)	Date change occurred (MM/DD/YYYY)

Section 5: BENEFICIARY DESIGNATION

☐ Primary	Name of beneficiary	%	Relationship to employee	Age
☐ Primary	Name of beneficiary	%	Relationship to employee	Age
☐ Contingent	Name of beneficiary	%	Relationship to employee	Age
☐ Contingent	Name of beneficiary	%	Relationship to employee	Age

Section 6: INSURANCE COVERAGE – Check all that you are enrolling for or rejecting. Coverage is limited to what is offered by employer.

Accept	Reject	
☐	☐	Basic Life (Please complete BENEFICIARY DESIGNATION in section 5)
☐	☐	Basic AD&D (Please complete BENEFICIARY DESIGNATION in section 5)
☐	☐	Basic Dependent Life
☐	☐	Short Term Disability (STD). If plan allows, include Buy-up STD? ☐ Yes ☐ No
☐	☐	Long Term Disability (LTD). If plan allows, include Buy-up LTD? ☐ Yes ☐ No
☐	☐	Voluntary Short Term Disability (VSTD)
☐	☐	Voluntary Long Term Disability (VLTD)
☐	☐	Voluntary Employee Life (complete section 5) _____ x annual earnings OR $ ____________ If plan allows, check to add one or both: ☐ Voluntary Dependent Life: Spouse $ ____________ Child $ ____________ ☐ Voluntary Employee AD&D: (equal to Voluntary Life amount) _____ x annual earnings OR $ ____________ If Voluntary AD&D amount is not equal to elected Voluntary Life amount: Spouse $ ____________ Child $ ____________

Accept	Reject	
☐	☐	Optional Life (only available with Basic Life) Optional Life: _____ x annual earnings OR $ ____________ If plan allows, check to add one or both: ☐ Optional Dependent Life: Spouse $ ____________ Child $ ____________ ☐ Optional Employee AD&D: (equal to Optional Life amount) _____ x annual earnings OR $ ____________ If Optional AD&D amount is not equal to elected Optional Life amount

Section 7: PORTABILITY — Complete only if exercising portability option. Attach check with enrollment.

Payment mode requested	Date coverage with employer terminated
☐ Monthly ☐ Quarterly ☐ Semi-annual ☐ Annual	

Portability options: Minimum employee coverage is $10,000, and employee coverage is required to transfer any dependent coverage. Dependent coverage may not exceed 50% of employee coverage.

Employee: ☐ Same ☐ Decrease to: ____________ ☐ Increase to: ____________ (for an increase, Section 8 must be completed) ☐ Delete coverage

Spouse: ☐ Same ☐ Decrease to: ____________ ☐ Increase to: ____________ (for an increase, Section 8 must be completed) ☐ Delete coverage

Children: ☐ Same ☐ Decrease to: ____________ ☐ Increase to: ____________ (for an increase, Section 8 must be completed) ☐ Delete coverage

Section 8: AUTHORIZATION — Read carefully before signing.

1. *I authorize the release of any medical records or information concerning claims, conditions or treatment of myself and for any dependents listed herein, by any provider of health services, pharmacy-related service organization, medical or medically-related facility, or the MIB Group, Inc., to Anthem Life Insurance Company (Anthem), its affiliates, and any administrators, reinsurers, agents, or other entity providing services on behalf of Anthem. This information will be used for purposes which include but are not limited to: processing this application for enrollment; group risk classification; detecting or preventing fraud or misrepresentation; internal and external audits; administration of claims; and quality improvement programs. Anthem will advise such entities that such information must be kept confidential to the extent necessary or as otherwise provided by law, and should not be used for any unlawful purpose. This information includes any records or knowledge about medical history; including sensitive services such as mental health, psychiatric, substance abuse, reproductive health, information relating to HIV virus or AIDS, sexually transmitted or other communicable diseases contained in such records, including but not limited to, all records of office visits, examinations, treatment, evaluation, diagnostic and laboratory testing, reports, consultations, hospital records, prescription history, records for treatment of substance abuse, psychiatric counseling, notes, correspondence, insurance and billing information for treatment or services rendered by any provider. I understand that Anthem may collect personal information about me from outside sources, and that both personal and privileged information may be collected and disclosed to third parties without my further authorization, and may no longer be protected by Federal privacy laws. I also understand that I have a right to see and correct personal information that Anthem collects about me, and that I may receive a more detailed description of my rights under this law by writing to Anthem.*
2. *Payment of proceeds shall be made in accordance with the terms of the group contract. Unless otherwise provided herein, if one or more life insurance beneficiaries are named, the proceeds due shall be paid in equal shares to the named beneficiaries surviving the insured. Beneficiaries may be changed by the insured employee's written notice to his or her employer.*
3. *These coverages will become effective on the date established by the provisions of the group contract and certificates issued thereunder. I understand that by enrolling for the type of coverage checked, I authorize deduction from my wages if necessary for the required premium for the coverage for which I am enrolling.*
4. *I am responsible for the timely notification to my employer of any changes that would make me or a dependent ineligible for coverage.*
5. *I am applying to enroll in the coverage selected on this enrollment. If I select a coverage, or a combination of coverages, not available to me and/or a class for which I am not eligible, I agree that my selection(s) is hereby automatically amended to be consistent with the employer's application.*
6. *I understand that Anthem Life Insurance Company reserves the right to accept or decline this enrollment and that no right whatsoever is created by this enrollment.*

I acknowledge that I have read the foregoing provisions and I expressly accept such provisions as a condition of coverage. I represent that the answers given to all questions on this enrollment are true and accurate to the best of my knowledge and belief, and I understand they are being relied on by the insurer in accepting this enrollment. I understand that any misstatements or failure to report new medical information prior to my effective date may result in a material change to coverage or premium rates. Any material misrepresentation or significant omission found in this enrollment may result in denial of benefits or rescission or cancellation of my coverage(s). This authorization, for purposes of processing this enrollment form, is valid from the date signed for a period of twenty-four months unless revoked by me in writing, which I may do at any time by contacting Anthem. A photocopy is as valid as the original.

I give this authorization for and on behalf of myself and my eligible dependents, including my children and my spouse (if spouse does not sign below, if covered by the Plan.). I am acting as their agent and representative.

Incomplete enrollments will be mailed back to you for completion. This may delay the effective date of your coverage.

Employee signature	Date (MM/DD/YYYY)
X	
Spouse signature	Date (MM/DD/YYYY)
X	

Section 9: WAIVER OF COVERAGE

I hereby certify that I have been given the opportunity to enroll for the available group life and disability benefits offered by my employer, the benefits have been explained to me, and I and/or my dependent(s) decline to participate in the rejected coverages noted in section 6. Neither I nor my dependent(s) were induced or pressured by my employer, agent, or life carrier, into declining this coverage, but elected of our own accord to decline coverage. I understand that if I or any of my dependent(s) wish to apply for such coverage in the future, I may be required to provide evidence of insurability at my expense.

Print employee name	
Employee signature	Date (MM/DD/YYYY)
X	

Fraud Warning: Any person who, with a purpose to injure, defraud, or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is subject to prosecution and punishment for insurance fraud, as provided in N.H. Rev. Stat. Ann. §638:20

NOTICE OF DIVORCE, LEGAL SEPARATION OR DISSOLUTION OF CIVIL UNION

THIS FORM MUST BE COMPLETED AND SIGNED BY THE ENROLLEE AS NOTIFICATION OF A COURT DECREE REGARDING DIVORCE, LEGAL SEPARATION OR DISSOLUTION OF A CIVIL UNION. HEALTHTRUST MAY REQUEST A COPY OF THE DECREE.

Enrollee's Name: ______________________ Date: ______________

Enrollee's Mailing Address: ______________________ Enrollee Date of Birth: ______________

Group Name: ______________________ Group Number: ______________

I hereby notify HealthTrust of the following event affecting my medical and/or dental plan coverage (check one):

❑ Divorce ❑ Legal Separation ❑ Dissolution of a Civil Union **Date of Decree:** ______________

Former Spouse or Civil Union Partner: My former spouse or civil union partner was covered as an eligible dependent under my group plan through my employer immediately prior to the issuance of such decree. The decree provides as follows with respect to the nature and payment terms of my former spouse or civil union partner's medical and/or dental plan coverage:

____

____

____

Children: The children listed below were covered as eligible dependents under my group plan through my employer immediately prior to the issuance of such decree. The decree provides as follows with respect to these dependent children's medical and/or dental plan coverage:

____

____

____

I understand that my spouse or former civil union partner and child(ren) may be entitled to continue coverage under my employer's medical and/or dental plan in certain situations pursuant to state or federal law.

Name of Former Spouse or Civil Union Partner: ______________________

Current Mailing Address: ______________________

Date of Birth: ______________________

Employer/Employment Status: ______________________

Name(s) of covered child(ren)	Date(s) of Birth	Address

____

Enrollee Signature Date

Form #HT008
Revision Date 9/15

WHITE COPY – EMPLOYEE YELLOW COPY – HEALTHTRUST PINK COPY – EMPLOYER

Complete only if a change in coverage due to divorce (ex: family plan to single)

MEDICAL AND/OR DENTAL APPLICATION AND CHANGE FORM

ENROLLEE (EMPLOYEE) INFORMATION

STEP 1

Last Name	First Name		MI
Mailing Address	City	State	Zip
Telephone	Is your position covered by a collective bargaining agreement? ❑ Yes ❑ No		
Employer Name Monadnock Regional School District SAU 93	If yes, check the appropriate category: ❑ Teacher ❑ Police ❑ Fire ❑ Public Works ❑ Other		

Marital Status
- ❑ Single
- ❑ Married
- ❑ Widowed
- ❑ Divorced/Legally Separated
- ❑ Other________________

TYPE OF COVERAGE AND MEMBERSHIP REQUESTED (check)

Medical Type		Medical Membership	Dental Type	Dental Membership
❑ BC3T5RDR-RX10/20/45 ❑ BC3T15IPDED - RX 10/20/45 ❑ AB5 - RX 10/20/45 ❑ AB20IPDED RX 10/20/45	❑ HDHP (Lumenos) ❑ Medicare Supplemental (Medicomp) ❑ With RX ❑ Without RX A PCP must be selected for HMO and is strongly recommended for POS	❑ Single ❑ Two-Person ❑ Family	Dental Option #_1C___	❑ 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 ________________

- ❑ Loss of Other Coverage (explain) ________________
- ❑ Election of COBRA Coverage
- ❑ Part-Time to Full-Time
- ❑ Other (explain) ________________

Actual Date of Event ________________

Office Use Only

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

STEP 3

NAME (First, MI, Last)	Social Security #	Date of Birth Month/Day/Year	Relation to Enrollee	Gender	Enroll(ed) in		Primary Care Provider (for HMO or POS Medical Type)		Current Patient
					Medical	Dental	PCP ID#	First/Last Name/City/State	
Employee Name		___/___/___	Self	❑ M ❑ F	❑	❑			❑ Y ❑ N
Spouse Name		___/___/___	Spouse	❑ M ❑ F	❑	❑			❑ Y ❑ N
Dependent Child Name**		___/___/___		❑ M ❑ F	❑	❑			❑ Y ❑ N
Dependent Child Name**		___/___/___		❑ M ❑ F	❑	❑			❑ Y ❑ N
Dependent Child Name**		___/___/___		❑ M ❑ F	❑	❑			❑ Y ❑ N

**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*.

STEP 4

OTHER MEDICAL INSURANCE COVERAGE INFORMATION

Do you or your family have medical coverage through another group or employer? ❑ Y ❑ N		
Are you or another dependent transferring coverage from another medical carrier? ❑ Y ❑ N		
Member Name	Name of Insurance Company	
Policy Number	Effective Date	Termination Date

OTHER DENTAL INSURANCE COVERAGE INFORMATION

Do you or your family have dental coverage through another group or employer? ❑ Y ❑ N		
Are you or another dependent transferring coverage from another dental carrier? ❑ Y ❑ N		
Member Name	Name of Insurance Company	
Policy Number	Effective Date	Termination Date

Are you or any of your dependents eligible for Medicare? ❑ Y ❑ N
Member Name ________________________

Part A (Hospital) Effective Date ___/___/___
Part B (Medical) Effective Date ___/___/___

Medicare Claim Number________________________
Is coverage due to end-stage renal disease? ❑ Y ❑ N

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 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.

Enrollee Signature____ Date ___/___/___

EMPLOYER USE ONLY

STEP 6

Date of Hire ___/___/___	Date of Rehire ___/___/___	❑ Full-Time	❑ Part-Time Number of Hours Weekly______	❑ COBRA	
Eligibility Organization Name Monadnock Regional School District SAU 93				Employee Job Title	
Medical Group/Carrier Number 363059M	Coverage Code	Effective Date of Coverage ___/___/___		Benefits Administrator Signature/Stamp	Date ___/___/___
Dental Group/Carrier Number 3116-	Coverage Code	Effective Date of Coverage ___/___/___			

White - HealthTrust Yellow - Employer Pink - Employee