

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? <div style="text-align: center;"><input type="checkbox"/> Yes <input type="checkbox"/> No</div>	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
<p>For Email changes: <input type="checkbox"/> Also update this address for <i>NHRS Email Updates</i> <input type="checkbox"/> Sign me up for <i>NHRS Email Updates</i> <small>Note: My Account users must log in to their personal account and manually change their email address for account authentication purposes.</small></p>	

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:

<input type="checkbox"/> Change/Update Address	New Address: Street: _____ City: _____ State: _____ Zip: _____ Phone: (____) _____ Email: _____
<input type="checkbox"/> Correct DOB	Name of Individual: _____ Relationship to Enrollee: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child Correct DOB: ____/____/____
<input type="checkbox"/> Correct Name Spelling	Incorrect Spelling: _____ Relationship to Enrollee: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child Correct Spelling: _____
<input type="checkbox"/> Change Name*	Name of Individual: _____ Relationship to Enrollee: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child New Name: _____ Reason for Name Change: <input type="checkbox"/> Marriage <input type="checkbox"/> Divorce <input type="checkbox"/> Other _____ <small>Please Explain</small>
<input type="checkbox"/> Gender Change	Name of Individual: _____ Relationship to Enrollee: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child Gender Change: From: <input type="checkbox"/> Male <input type="checkbox"/> Female To: <input type="checkbox"/> Male <input type="checkbox"/> 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.