

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 <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.
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 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

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SUBSCRIBER (EMPLOYEE) INFORMATION

S T E P 1	Last Name		First Name		MI
	Social Security #		Telephone		
	Mailing Address		City	State	Zip
	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		Employer Name		
	Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Civil Union Partnership <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced/Legally Separated		TYPE OF COVERAGE AND MEMBERSHIP REQUESTED (check)		
Dental Type Dental Option # _____			Dental Membership <input type="checkbox"/> Single <input type="checkbox"/> Two-Person <input type="checkbox"/> Family		

S T E P 2	REASON FOR COMPLETING FORM	
	<input type="checkbox"/> Benefit Change/Transfer <input type="checkbox"/> Open Enrollment <input type="checkbox"/> Name Change <input type="checkbox"/> Marriage <input type="checkbox"/> Civil Union <input type="checkbox"/> Birth/Adoption <input type="checkbox"/> Death <input type="checkbox"/> Divorce/Legal Separation <input type="checkbox"/> Civil Union Dissolution	<input type="checkbox"/> Dependent No Longer Eligible <hr/> 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 _____	

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

S T E P 3	NAME (First, MI, Last)	Date of Birth Month/Day/Year	Relation to Subscriber	Gender
	Employee Name	__/__/__	Self	<input type="checkbox"/> Male <input type="checkbox"/> Female
	Spouse/Civil Union Partner Name	__/__/__	Spouse/Civil Union Partner	<input type="checkbox"/> Male <input type="checkbox"/> Female
	Dependent Name**	__/__/__		<input type="checkbox"/> Male <input type="checkbox"/> Female
	Dependent Name**	__/__/__		<input type="checkbox"/> Male <input type="checkbox"/> Female
	Dependent Name**	__/__/__		<input type="checkbox"/> Male <input type="checkbox"/> 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

S T E P 4	Do you or your family have dental coverage through another group or employer? <input type="checkbox"/> Yes <input type="checkbox"/> No	Name of Insurance Company	
	Are you or another dependent transferring coverage from another dental carrier? <input type="checkbox"/> Yes <input type="checkbox"/> No	Policy Number	
	Member Name	Effective Date	Termination Date

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 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		
	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**	___/___/___		<input type="checkbox"/> Male <input type="checkbox"/> Female
Dependent Name**	___/___/___		<input type="checkbox"/> Male <input type="checkbox"/> Female
Dependent Name**	___/___/___		<input type="checkbox"/> Male <input type="checkbox"/> Female
Dependent Name**	___/___/___		<input type="checkbox"/> Male <input type="checkbox"/> Female
Dependent Name**	___/___/___		<input type="checkbox"/> Male <input type="checkbox"/> 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 ___/___/___