



LIFE, LONG-TERM DISABILITY (LTD), AND/OR SHORT-TERM DISABILITY (STD) APPLICATION AND CHANGE FORM

WELCOME TO HEALTHTRUST

Use this form to change your beneficiary(ies) as well as to enroll in or change your disability and/or life insurance coverage. If you only need to change your mailing address, do not complete this form; instead, call HealthTrust's Enrollee Services Department at 800.527.5001 and notify your employer.

BE SURE TO FILL OUT EACH SECTION COMPLETELY. Failure to complete each section in full could delay the start of coverage.

HOW TO COMPLETE THIS FORM

Remove this cover sheet before you begin.

STEP 1	EMPLOYEE INFORMATION Complete this section with your personal information, using your full legal name. Select the type of HealthTrust-sponsored life and/or disability coverage you are requesting. Please limit your selection to only those coverages offered by your employer and for which you are eligible. Some life and disability coverages may require evidence of insurability. You will not be eligible for any amount greater than the evidence of insurability requirement if you do not submit an <i>Evidence of Insurability</i> form; this form may be obtained from your employer or HealthTrust. You will be added for an amount greater than the evidence of insurability requirement once approved. For more information, refer to your certificate of coverage.
STEP 2	REASON FOR COMPLETING APPLICATION Use this section to indicate the reason(s) for completing form.
STEP 3	BENEFICIARY INFORMATION Please name your beneficiary(ies) for your life and/or disability coverages. If you wish to name a different beneficiary(ies) for your life, long-term disability (LTD), and/or short-term disability (STD) coverages, attach a separate piece of paper containing all necessary information. Otherwise, your beneficiary(ies) will be the same for all coverages. You may name more than one beneficiary. If you specify benefit percentages, the total must equal 100 percent. If you do not specify benefit percentages, benefits will be paid in equal shares. If you do not name a beneficiary(ies) – or if neither your primary nor contingent beneficiary(ies) survive you – benefits will be paid in order of survivorship shown in your certificate of coverage. Your primary beneficiary(ies) are the person(s) you name to receive benefits. Your contingent beneficiary(ies) are the person(s) you name to receive benefits if your primary beneficiary(ies) do not survive you.
STEP 4	EMPLOYEE SIGNATURE Sign and date this form; return completed form to your employer (retain the pink copy for your records).
STEP 5	EMPLOYER USE ONLY Employer must review this form and verify that steps 1-4 are completed. Employer must complete this section and forward to HealthTrust for processing at: PO Box 617, Concord, NH 03302, or through the Secure Message Center in your Secure Member Portal (SMP) account, email enrolleeservices@healthtrustnh.org or fax 603.226.2988



Questions? Please call us at 800.527.5001, Monday through Friday, 8:30 a.m. to 4:30 p.m.

Form #HT036
Revision Date 11/15/2022

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EMPLOYEE INFORMATION

STEP 1	Last Name		First Name	MI
	Social Security #		Date of Birth	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female
	Mailing Address			Telephone
	City	State	Zip	
	Employer Name			
	Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced/Legally Separated		TYPE OF COVERAGE REQUESTED (check)	
		Life Coverage <input type="checkbox"/> Basic Life <input type="checkbox"/> Supplemental Life <input type="checkbox"/> Dependent Life	Disability Coverage <input type="checkbox"/> Long-Term Disability <input type="checkbox"/> Short-Term Disability	

STEP 2	REASON FOR COMPLETING FORM
	<input type="checkbox"/> New Enrollee <input type="checkbox"/> Name Change <input type="checkbox"/> Benefit Change <input type="checkbox"/> Change in Beneficiary ONLY <input type="checkbox"/> Part Time to Full Time <input type="checkbox"/> Other _____
	Actual Date of Event _____

BENEFICIARY INFORMATION

STEP 3	Name of Beneficiary	Date of Birth	Relation to Employee	Social Security #	Benefit Percentage
	Primary Beneficiary				%
	Primary Beneficiary				%
	Primary Beneficiary				%
					Total: 100%
	Contingent Beneficiary				%
	Contingent Beneficiary				%
					Total: 100%

ENROLLEE SIGNATURE

STEP 4	I hereby authorize HealthTrust and my employer to institute the action(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 and beneficiary designation(s) to be made valid. By signing this application, I attest to the accuracy and truthfulness and will provide documentation to HealthTrust upon request.
	Enrollee Signature _____ Date ____/____/____

EMPLOYER USE ONLY

STEP 5	Date of Hire	Date of Rehire	Billing Group Name	
	Full-Time Number of Hours	Part-Time Number of Hours	Base Annual Salary	Employee Job Title
	Basic Life Coverage		Additional Life Coverage	Long-Term Disability Coverage
	Class Number	<input type="checkbox"/> Supplemental	Class Number	Short-Term Disability Coverage
	Effective Date of Coverage	<input type="checkbox"/> Dependent	Effective Date of Coverage	Effective Date of Coverage
	Basic Life Benefit Amount		Benefit Administrator Signature/Stamp	Date
	Supplemental Life Benefit Amount			