



Retirees who live PERMANENTLY outside of New England

Please send form to:
 City of Manchester
 Human Resources/Benefits
 One City Hall Plaza
 Manchester, NH 03101
 Phone (603) 624-6543 Fax (603) 628-6065
 benefitscoordinator@manchesternh.gov

	Date of Retirement	Effective Date								
MEDICAL BENEFIT OPTIONS (refer to your collective bargaining agreement for eligible plans & cost share)										
Available to all Retirees										
Lumenos HDHP-National Single \$694.29 2-Person \$1,395.62 Family \$1,867.74	HMO PPO-Out of State Single \$909.48 2-Person \$1,828.05 Family \$2,446.46									
Employee Name (Last) _____ (M.I.) _____		Home Phone # _____								
		Employee DOB _____								
		Employee SSN _____								
Address (Street) _____ (City) _____ (State) _____ (Zip Code) _____		Home E-Mail Address _____								
Last Name	First Name	M. I.	Date of Birth	Social Security # (Required)	Gender	Relation to Subscriber	Full Time Student (ages 19-25)	Doctors Full Name and PCP# (required for both HMO & POS) (Leave PCP# blank if you can't find it)	Existing Patient	
EMPLOYEE (As Above)			As Above	As Above	<input type="checkbox"/> Male <input type="checkbox"/> Female	Self	N / A	Name _____ PCP # _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Spouse (Whom you wish to cover or remove)					<input type="checkbox"/> Male <input type="checkbox"/> Female	Spouse	N / A	Name _____ PCP # _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Dependent (Whom you wish to cover or remove)					<input type="checkbox"/> Male <input type="checkbox"/> Female		<input type="checkbox"/> Yes <input type="checkbox"/> No	Name _____ PCP # _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Dependent (Whom you wish to cover or remove)					<input type="checkbox"/> Male <input type="checkbox"/> Female		<input type="checkbox"/> Yes <input type="checkbox"/> No	Name _____ PCP # _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Dependent (Whom you wish to cover or remove)					<input type="checkbox"/> Male <input type="checkbox"/> Female		<input type="checkbox"/> Yes <input type="checkbox"/> No	Name _____ PCP # _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Dependent (Whom you wish to cover or remove)					<input type="checkbox"/> Male <input type="checkbox"/> Female		<input type="checkbox"/> Yes <input type="checkbox"/> No	Name _____ PCP # _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	
<p>My signature below confirms that the premium rate associated with the selected plan has been made available to me. My signature also authorizes those premiums to be deducted from my weekly paycheck.</p>										
Employee Signature					Date Completed		Employer's Signature			Date Entered

FY 2021