



# HEALTH INSURANCE ENROLLMENT/CHANGE FORM FOR RETIREES

*(Administered by Anthem Blue Cross and Blue Shield in New Hampshire)*

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 Change	Effective Date
<b>MEDICAL BENEFIT OPTIONS</b>		
Please Select The Appropriate Retirement Group:		Home Phone #
		Home E-Mail Address
Retiree Name (Last)	(first)	(M.I.)
		Retiree Date of Birth
		Retiree Social Security #
Address (Street)	(City)	(State)
		(Zip Code)

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# <i>(If left blank Anthem will assign a doctor) (Leave PCP# blank if you can't find it)</i>	Existing Patient
RETIREE ( 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 <i>(Whom you wish to cover or remove)</i>					<input type="checkbox"/> Male <input type="checkbox"/> Female	Spouse	N / A	Name _____ PCP # _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
Dependent <i>(Whom you wish to cover or remove)</i>					<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 <i>(Whom you wish to cover or remove)</i>					<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 <i>(Whom you wish to cover or remove)</i>					<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 <i>(Whom you wish to cover or remove)</i>					<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

Other Health Care Coverage:  
**Do you or your dependents have other health insurance under a group plan, HMO or Medicare?**  No  Yes (if yes, include a photocopy of the insurance card front & back)

Name of person covered	SSN or Medicare #	Effective Date	End Date	Medicare Part A	Medicare Part B	Medicaid	Other Insurance Carrier
				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Employee Signature	Date Completed	Employer's Signature	Date Entered
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