



HEALTH INSURANCE ENROLLMENT/CHANGE FORM FOR ACTIVE EMPLOYEES

(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 Hire	Date of Change	Effective Date
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MEDICAL BENEFIT OPTIONS

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Please select a Division:

- Airport Airport/Union Aldermen Assessors BMD/Fac BMD/Fac-Union City Clerk City Solicitor EPD EPD/Union Eld. Services Finance Fire
 Fire Chiefs/Union Fire/Union Health Health/Union Hwy Hwy/Union HR Info Systems Library Library/Union Mayor MEDO OYS Parking
 Parks & Rec Parks & Rec/Union Plan&Comm Dev Police/Non Aff. Police/PDSS Police/Maps Police MPPA Tax Water Water/Union Welfare

Employee Name (Last)	(first)	(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

Other Health Care Coverage:

Do you or your dependents have other health insurance under a group plan, HMO or Medicare? No Yes (if yes, please provide the following information)

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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