



EXISTING EMPLOYEES

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	Cost Share 80/20 Other	Effective Date											
MEDICAL BENEFIT OPTIONS (refer to your collective bargaining agreement for eligible plans & cost share)															
	HDHP With HSA			HDHP Without HSA			250 SOS PLAN								
	Single	2-Person	Family	Single	2-Person	Family	Single	2-Person	Family						
SOS 100 AFSCME	POS SOS 100 AFSCME			250 POS SOS PLAN AFSCME, IAFF and MAFS			POS Welfare, Water, NonAffiliated		POS 80/20 Welfare, Water, NonAffiliated						
Single 2-Person Family	Single 2-Person Family			Single 2-Person Family			Single 2-Person Family		Single 2-Person Family						
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 _____			<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 _____			<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 _____			<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 _____			<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 _____			<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 _____			<input type="checkbox"/> Yes <input type="checkbox"/> No				
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.															
Employee Signature					Date Completed		Employer's Signature					Date Entered			

[Click here for current insurance rates](#)