



Contributory Retirement

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 Contributory Retirees		Available only to AFSCME Retirees
Lumenos HDHP-Regional	HMO 250 SOS PLAN	HMO 100 SOS PLAN
Single \$694.29 2-Person \$1,395.62 Family \$1,867.74	Single \$866.97 2-Person \$1,742.63 Family \$2,332.12	Single \$882.20 2-Person \$1,773.20 Family \$2,373.07
		POS 100 SOS PLAN
		Single \$1,274.00 2-Person \$2,560.73 Family \$3,427.04
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
		<input type="checkbox"/> Male <input type="checkbox"/> Female
Spouse (Whom you wish to cover or remove)		Spouse
		<input type="checkbox"/> Male <input type="checkbox"/> Female
Dependent (Whom you wish to cover or remove)		<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Male <input type="checkbox"/> Female
Dependent (Whom you wish to cover or remove)		<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Male <input type="checkbox"/> Female
Dependent (Whom you wish to cover or remove)		<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Male <input type="checkbox"/> Female
Dependent (Whom you wish to cover or remove)		<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Male <input type="checkbox"/> Female
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

FY 2021