HEALTH INSURANCE ENROLLMENT/CHANGE FORM

NHRS: Fire and Police Retirees

(Administered by Anthem Blue Cross & Blue Shield of NH)

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

Decline Coverage ☐	Type of Change: ☐ Change of Address or Name Change	☐ New Enrollment ☐ Open Enrollment	☐ Add Dependent (s) ☐ Cancel/Terminate	☐ Remove Dependent (s) ☐ Change Benefit Option	Date of Retirement	Effective Date

***MEDICAL BENEFIT OPTIONS** (refer to your collective bargaining agreement for eligible plans & cost share)*

	Available to Fire and Police Retirees		**Available only to Fire Retirees**
	Lumenos HDHP	250 SOS PLAN	POS 250 SOS PLAN
	☐ **Single** **$694.29**	☐ **Single** **$866.97**	☐ **Single** **$1,251.68**
	☐ **2-Person** **$1,395.62**	☐ **2-Person** **$1,742.63**	☐ **2-Person** **$2,515.85**
	☐ **Family** **$1,867.74**	☐ **Family** **$2,332.12**	☐ **Family** **$3,366.97**

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	ADD/DELETE (adult children up to age 26)	Doctors Full Name and PCP# *(If left blank Anthem will assign a doctor) (Leave PCP# blank if you can't find it)*	Existing Patient
EMPLOYEE (As Above)	As Above	As Above	☐ Male ☐ Female	Self		Name PCP #	☐ Yes ☐ No
Spouse *(Whom you wish to cover or remove)*			☐ Male ☐ Female	Spouse		Name PCP #	☐ Yes ☐ No
Dependent *(Whom you wish to cover or remove)*			☐ Male ☐ Female			Name PCP #	☐ Yes ☐ No
Dependent *(Whom you wish to cover or remove)*			☐ Male ☐ Female			Name PCP #	☐ Yes ☐ No
Dependent *(Whom you wish to cover or remove)*			☐ Male ☐ Female			**Name** PCP #	☐ Yes ☐ No
Dependent *(Whom you wish to cover or remove)*			☐ Male ☐ Female			Name PCP #	☐ Yes ☐ 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

FY 2021