

State of NH Employees - Benefit Enrollment and Life Event Change Form

A	<input type="checkbox"/> Adding Dependent (check one)	<input type="checkbox"/> Removing Dependent (check one)	<input type="checkbox"/> New Enrollment (check one)	Employer Name and Address: State of New Hampshire 28 School St, Concord, NH 03301	
	<input type="checkbox"/> Marriage <input type="checkbox"/> Birth <input type="checkbox"/> Legal Guardianship/Court Order <input type="checkbox"/> Adoption <input type="checkbox"/> Loss of Other Coverage	<input type="checkbox"/> Divorce/Legal Separation <input type="checkbox"/> Death <input type="checkbox"/> Access to Other Coverage	<input type="checkbox"/> New Hire or <input type="checkbox"/> Rehire < 1 year <input type="checkbox"/> PT employee, benefit eligible <input type="checkbox"/> Return from LOA <input type="checkbox"/> RIF or Recall Placement <input type="checkbox"/> Loss of Other Coverage	Employee Social Security #: NH FIRST Employee ID #:	Union Affiliate: <input type="checkbox"/> SEA <input type="checkbox"/> UNREPRESENTED <input type="checkbox"/> TROOPER <input type="checkbox"/> NEPBA 040 <input type="checkbox"/> NEPBA 045 <input type="checkbox"/> NEPBA 260 <input type="checkbox"/> NEPBA 265 <input type="checkbox"/> NEPBA 270 <input type="checkbox"/> TEAMSTERS 633 (formerly NEPBA 250)
B	Employee Name (PLEASE PRINT): <i>(First Name Middle Initial Last Name)</i>			Employee Date of Birth: (MM/DD/YYYY)	
				____/____/____	
			Work Phone: _____		
			Home Phone: _____		
Mailing Address (Street) _____			(City) _____ (State) _____ (Zip Code) _____		

C	First Name	Middle Initial	Last Name	Add, Waive or Remove	Date of Birth	Gender	Coverage Selection	FSA Elections <i>(Note: FSA start date will be the same as your benefits effective date)</i>
Employee	SAME AS ABOVE			<input type="checkbox"/> Add (specify under Coverage Selection) <input type="checkbox"/> Waive Medical <input type="checkbox"/> Waive Dental	SAME AS ABOVE	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Dental <input type="checkbox"/> Medical <input type="checkbox"/> HMO <input type="checkbox"/> POS	<input type="checkbox"/> Medical (\$2500 max) \$ _____ / Year <input type="checkbox"/> Waive Medical FSA <input type="checkbox"/> Child Care (\$5000 max) \$ _____ / Year <input type="checkbox"/> Waive Child Care FSA
	Spouse/Same Gender Spouse		Relationship <input type="checkbox"/> Spouse <input type="checkbox"/> Same Gender Spouse	<input type="checkbox"/> Add <input type="checkbox"/> Remove	Date of Birth ____/____/____	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Dental <input type="checkbox"/> Medical	Please attach marriage certificate if newly adding a spouse.
Additional dependent children should be listed on a second form.	Dependent		Relationship <input type="checkbox"/> Employee's Dependent <input type="checkbox"/> Dependent of Same Gender Spouse	<input type="checkbox"/> Add <input type="checkbox"/> Remove	Date of Birth ____/____/____	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Dental <input type="checkbox"/> Medical	Please attach birth certificate if newly adding a child.
	Dependent		Relationship <input type="checkbox"/> Employee's Dependent <input type="checkbox"/> Dependent of Same Gender Spouse	<input type="checkbox"/> Add <input type="checkbox"/> Remove	Date of Birth ____/____/____	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Dental <input type="checkbox"/> Medical	Please attach birth certificate if newly adding a child.
	Dependent		Relationship <input type="checkbox"/> Employee's Dependent <input type="checkbox"/> Dependent of Same Gender Spouse	<input type="checkbox"/> Add <input type="checkbox"/> Remove	Date of Birth ____/____/____	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Dental <input type="checkbox"/> Medical	Please attach birth certificate if newly adding a child.

D	<i>The information provided above is true and correct to the best of my knowledge. I also understand that the dependent coverage will not be effective until I provide appropriate documentation to my agency Human Resource office.</i>					
	Employee Signature: _____			Date: ____/____/____		
** Please make a copy of this form for your personal records**						

For Agency Benefit Representative Use Only	Agency Name	Agency Benefit Representative Name	Contact #	Date Sent to DOP	Event Date (Date of Hire or Life Event)	Coverage Start or End Date
Payroll #: _____						

FOR DOP USE ONLY: Date NH FIRST Updated: _____ Initials: _____