

## Benefit Enrollment and Life Event Change Form - Courts

<b>A</b>	<input type="checkbox"/> New Enrollment (check one)	<input type="checkbox"/> Adding Dependent (check one)	<input type="checkbox"/> Removing Dependent (check one)	Employer Name and Address: <b>State of New Hampshire 28 School St, Concord, NH 03301</b>		
	<input type="checkbox"/> New Hire <input type="checkbox"/> Rehire < 1 year or <input type="checkbox"/> Rehire > 1 year <input type="checkbox"/> RIF or Recall Placement <input type="checkbox"/> PT/FT not benefit eligible to PT/FT benefit eligible <input type="checkbox"/> Loss of Other Coverage <input type="checkbox"/> Return from LOA which resulted in loss of benefits	<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"/> Court Order <input type="checkbox"/> Age Out – Turning 26	Employee Social Security #: _____  NH FIRST Employee ID #: _____	Union Affiliate: <input type="checkbox"/> JB SEA (JBSEA) <input type="checkbox"/> JB UNREPRESENTED (JBUR) <input type="checkbox"/> JB TEAMSTERS 633 (JBTEAM633)	
<b>B</b>	Employee Name (PLEASE PRINT): (First Name Middle Initial Last Name)			Employee Date of Birth: (MM/DD/YYYY) _____/_____/_____		Work Phone: _____
	Mailing Address (Street) _____ (City) _____ (State) _____ (Zip Code) _____					Home Phone: _____

	First Name	Middle Initial	Last Name	Add, Waive or Remove	Date of Birth	Gender	Coverage Selection (Choose one for Dental and one for Medical)	Flexible Spending (FSA) Elections (Choose one for Medical FSA and one for Dependent Childcare FSA)	
<b>C</b>	Employee  <b>SAME AS ABOVE</b>			<input type="checkbox"/> Add (specify under Coverage Selection)  <input type="checkbox"/> Waive or Remove (specify under Coverage Selection)	<b>SAME AS ABOVE</b>		<input type="checkbox"/> M  <input type="checkbox"/> F	<input type="checkbox"/> Enroll in Dental or <input type="checkbox"/> Waive/End Dental  Enroll in Medical: <input type="checkbox"/> HMO or <input type="checkbox"/> POS or <input type="checkbox"/> Waive/End Medical Coverage	<input type="checkbox"/> Enroll in Medical FSA (\$2500/year max) \$ _____ / Year or <input type="checkbox"/> Waive Medical FSA  <input type="checkbox"/> Enroll in Dependent Childcare FSA (\$5000/year max) Note: child must be under age 13 to be eligible \$ _____ /Year or <input type="checkbox"/> Waive Dependent Childcare FSA
	Spouse/Same Gender Spouse		<b>Relationship</b> <input type="checkbox"/> Spouse <input type="checkbox"/> Same Gender Spouse		<input type="checkbox"/> Add  <input type="checkbox"/> Waive or Remove	Date of Birth _____/_____/_____	<input type="checkbox"/> M  <input type="checkbox"/> F	<input type="checkbox"/> Enroll in Dental or <input type="checkbox"/> Waive/End Dental  <input type="checkbox"/> Enroll in Medical or <input type="checkbox"/> Waive/End Medical	Please attach supporting documentation based on event type. <b>Adding</b> - marriage certificate or proof of loss of coverage. <b>Removing</b> - divorce decree, death certificate, proof of other insurance, etc.
<b>Additional dependent children should be listed on a second form.</b>	Dependent		<b>Relationship</b> <input type="checkbox"/> Employee's Dependent <input type="checkbox"/> Dependent of Same Gender Spouse		<input type="checkbox"/> Add  <input type="checkbox"/> Waive or Remove	Date of Birth _____/_____/_____	<input type="checkbox"/> M  <input type="checkbox"/> F	<input type="checkbox"/> Enroll in Dental or <input type="checkbox"/> Waive/End Dental  <input type="checkbox"/> Enroll in Medical or <input type="checkbox"/> Waive/End Medical	Please attach supporting documentation based on event type. <b>Adding</b> - birth certificate, adoption paperwork, court order, proof of loss of coverage, etc. <b>Removing</b> – proof of other insurance, death certificate, court order, etc.
	Dependent Name: _____				<input type="checkbox"/> Add  <input type="checkbox"/> Waive or Remove	Date of Birth _____/_____/_____	<input type="checkbox"/> M  <input type="checkbox"/> F	<input type="checkbox"/> Enroll in Dental or <input type="checkbox"/> Waive/End Dental  <input type="checkbox"/> Enroll in Medical or <input type="checkbox"/> Waive/End Medical	Please attach supporting documentation based on event type. <b>Adding</b> - birth certificate, adoption paperwork, court order, proof of loss of coverage, etc. <b>Removing</b> – proof of other insurance, death certificate, court order, etc.
	Dependent SSN: _____ - _____ - _____								

<b>D</b>	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.					
Employee Signature: _____			Date: ____/____/_____			<b>** Please make a copy of this form for your personal records**</b>

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 #: _____						