

## 2014 Open Enrollment Form – State of New Hampshire Employees

<b>A</b>	<input type="checkbox"/> New Enrollment (check all that apply)	<input type="checkbox"/> Removing Coverage (check all that apply)	Employer Name and Address: <b>State of New Hampshire</b> <b>28 School Street, Concord, NH 03301</b>		
	<input type="checkbox"/> Newly Enrolling Self <input type="checkbox"/> Adding Spouse <input type="checkbox"/> Adding Child(ren) <input type="checkbox"/> Enrolling in 2014 Medical FSA <input type="checkbox"/> Enrolling in 2014 Dep Child Care FSA	<input type="checkbox"/> Waiving medical or dental for Self <input type="checkbox"/> Removing Spouse <input type="checkbox"/> Removing Child(ren)	Employee Social Security #: _____  NH FIRST Employee ID #: _____	<b>Union Affiliate:</b> <input type="checkbox"/> SEA <input type="checkbox"/> TEAMSTERS 633 (FKA - NEPBA 250) <input type="checkbox"/> TROOPER <input type="checkbox"/> NEPBA 260 <input type="checkbox"/> UNREPRESENTED <input type="checkbox"/> HR CONFIDENTIAL <input type="checkbox"/> NEPBA 040 <input type="checkbox"/> NEPBA 265 <input type="checkbox"/> NEPBA 045 <input type="checkbox"/> NEPBA 270	
<b>B</b>	Employee Name (PLEASE PRINT):    (First Name    Middle Initial    Last Name)		Employee Date of Birth: (MM/DD/YYYY) _____/_____/_____		Work Phone: _____
	Address (Street) _____ (City) _____ (State) _____ (Zip Code) _____		Home Phone: _____		

<b>C</b>	First Name	Middle Initial	Last Name	Add, Waive or Remove	Date of Birth	Gender	Coverage Selection	2014 FSA Elections	ANTHEM PCP NUMBER (If a name is entered without a number, no PCP will be assigned)	Existing Patient
Employee	<b>SAME AS ABOVE</b>			<input type="checkbox"/> Add (specify under Coverage Selection)  <input type="checkbox"/> Waive Medical  <input type="checkbox"/> Waive Dental	<b>SAME AS ABOVE</b>	<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"/> Dep Child Care (\$5000 max) \$ _____ / Year  <input type="checkbox"/> Waive Dep Child Care FSA		<input type="checkbox"/> Yes  <input type="checkbox"/> No
Spouse/Same Gender Spouse	Relationship <input type="checkbox"/> Spouse <input type="checkbox"/> Same Gender Spouse		Name: _____  Spouse's SSN: _____ - _____ - _____	<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 <input type="checkbox"/> HMO <input type="checkbox"/> POS	N/A		<input type="checkbox"/> Yes  <input type="checkbox"/> No
Dependent	Relationship <input type="checkbox"/> Employee's Dependent <input type="checkbox"/> Dependent of Same Gender Spouse		Dependent Name: _____  Dependent SSN: _____ - _____ - _____	<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 <input type="checkbox"/> HMO <input type="checkbox"/> POS	N/A		<input type="checkbox"/> Yes  <input type="checkbox"/> No
Dependent	Relationship <input type="checkbox"/> Employee's Dependent <input type="checkbox"/> Dependent of Same Gender Spouse		Dependent Name: _____  Dependent SSN: _____ - _____ - _____	<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 <input type="checkbox"/> HMO <input type="checkbox"/> POS	N/A		<input type="checkbox"/> Yes  <input type="checkbox"/> No

<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 (if applicable)	Effective Date
<b>Payroll #:</b> _ _ _ _					<b>1-1-2014</b>