

2015 Open Enrollment Form (SAG's) – State of New Hampshire Employees

A	<input type="checkbox"/> New Enrollment (check all that apply)	<input type="checkbox"/> Waiving/Removing Coverage <i>(check all that apply)</i>	<input type="checkbox"/> Changing Plans <i>(check which applies)</i>	Employer Name and Address: State of New Hampshire 28 School Street, Concord, NH 03301	
	<input type="checkbox"/> Newly Enrolling Self <input type="checkbox"/> Newly Enrolling Spouse <input type="checkbox"/> Newly Enrolling Child(ren) <input type="checkbox"/> Enrolling in 2015 Medical FSA <input type="checkbox"/> Enrolling in 2015 Dep Child Care FSA	<input type="checkbox"/> Waiving medical or dental for Self <input type="checkbox"/> Removing coverage for Spouse <input type="checkbox"/> Removing coverage for Child(ren)	<input type="checkbox"/> HMO to POS <input type="checkbox"/> POS to HMO	Employee Social Security #: _____ _____-_____-_____ NH FIRST Employee ID #: _____	Email Address: _____ Work Phone: _____
B	Employee Name (PLEASE PRINT): First Name MI Last Name			Employee Date of Birth: (mm/dd/yyyy) ____/____/____	
	Mailing Address (PLEASE PRINT) City State Zip Code				

C	First Name MI Last Name	Add, Change or Waive/Remove	Date of Birth	Gender	Coverage Selection if Newly Adding	
Employee	SAME AS ABOVE	<input type="checkbox"/> Add or Change <i>(specify under Coverage Selection)</i> <input type="checkbox"/> Waive Medical <input type="checkbox"/> Waive Dental	SAME AS ABOVE	<input type="checkbox"/> M <input type="checkbox"/> F	Dental <input type="checkbox"/> Medical <i>(choose one):</i> HMO <input type="checkbox"/> or POS <input type="checkbox"/>	2015 Flexible Spending (FSA) Elections <i>If you wish to participate in the Medical FSA and/or the Dependent Child Care FSA, please contact your Agency Benefit Representative for the appropriate FSA Enrollment Form.</i>
Spouse	First Name MI Last Name Name: _____ SSN: _____-_____-_____	<input type="checkbox"/> Add <i>(specify under Coverage Selection)</i> <input type="checkbox"/> Remove Medical <input type="checkbox"/> Remove Dental	Date of Birth ____/____/____	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Dental <input type="checkbox"/> Medical	If newly adding a spouse to your coverage, please attach marriage certificate for supporting documentation.
**Additional children should be listed on a second enrollment form.	Child #1 First Name MI Last Name Name: _____ SSN: _____-_____-_____	<input type="checkbox"/> Add <i>(specify under Coverage Selection)</i> <input type="checkbox"/> Remove Medical <input type="checkbox"/> Remove Dental	Date of Birth ____/____/____	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Dental <input type="checkbox"/> Medical	If newly adding a child to your coverage, please attach birth certificate and additional supporting documentation (ie: adoption paperwork or court order), if applicable.
	Child #2** First Name MI Last Name Name: _____ SSN: _____-_____-_____	<input type="checkbox"/> Add <i>(specify under Coverage Selection)</i> <input type="checkbox"/> Remove Medical <input type="checkbox"/> Remove Dental	Date of Birth ____/____/____	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Dental <input type="checkbox"/> Medical	If newly adding a child to your coverage, please attach birth certificate and additional supporting documentation (ie: adoption paperwork or court order), if applicable.

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 (if applicable)	Effective Date
Payroll #: ____-____-____					1-1-2015