

2016 Open Enrollment Form – 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 2016 Medical FSA <input type="checkbox"/> Enrolling in 2016 Dep Child Care FSA	<input type="checkbox"/> Waiving Medical for self in 2016 <input type="checkbox"/> Waiving Dental for self in 2016 <input type="checkbox"/> Removing coverage for Spouse <input type="checkbox"/> Removing coverage for Child(ren)	<input type="checkbox"/> POS to HMO <input type="checkbox"/> HMO to POS	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				

	First Name MI Last Name	Add, Change or Waive/Remove	Date of Birth	Gender	Coverage Selection if Newly Adding	2016 Flexible Spending (FSA) Elections <i>(Select one option for Medical FSA and one option for Dependent Child Care FSA)</i>	
C	Employee	<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"/>	<input type="checkbox"/> Enroll in Medical FSA (\$2500/year max) \$ _____ / Year OR <input type="checkbox"/> Waive Medical FSA for 2016 <input type="checkbox"/> Enroll in Dependent Child Care FSA (\$5000/year max) \$ _____ / Year OR <input type="checkbox"/> Waive Dependent Child Care FSA for 2016	
	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	<p>IF NEWLY ENROLLING A SPOUSE, you must provide copy of marriage certificate AND ONE of the following documents: 1) Page 1 of employee's current Federal Income Tax Return and one of the following: a) signature page with names and signatures of employee and spouse; or b) email confirmation of certificate of filing listing the spouse; 2) mortgage statement; 3) home equity loan statement; 4) lease agreement; 5) automobile registration; 6) credit card or account statement; 7) utility bill; 8) property tax document. Items 2 – 7 must be dated within the last 90 days. If the document lists the spouse only, it must reflect an address that is the same as the employee's address.</p> <p>IF NEWLY ENROLLING A CHILD, you must provide a copy of the birth certificate listing the employee as parent. STEP-CHILD, you must provide copy of birth certificate and marriage certificate listing spouse as parent. ADOPTED CHILD, you must provide copy of adoption paperwork or birth certificate listing employee as a parent. LEGAL GUARDIAN/COURT ORDER, you must provide birth certificate and court order signed by a judge verifying legal custody of the child; or Medical Support Order (QMCSO) issued by a state agency.</p> <p style="text-align: center;">PLEASE REFER TO THE ACTIVE EMPLOYEE BENEFIT ENROLLMENT GRID FOR MORE DETAILS</p>
	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	
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		
Child #3**	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		

Agency Contact Person:	Phone #:	Date Sent to DOP:
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NOTE: EMPLOYEE MUST SIGN THE ACTIVE EMPLOYEE BENEFIT ENROLLMENT ATTESTATION ON REVERSE SIDE OF THIS FORM

Active Employee Benefit Enrollment Attestation

1. I acknowledge that deductions of the required contributions toward the cost of coverage will be automatically taken from my pay.
2. Benefit elections under the plan can be changed or revoked by me at each annual open enrollment or during the plan year on account of and consistent with a Special Enrollee and/or qualifying life event, or as otherwise permitted by federal law. Special Enrollee and/or qualifying life event changes will only be permitted if requested within the required timeframe and supported by required documentation.
3. I understand that benefits are governed by and subject to the conditions stated in the applicable Benefits Booklet and other governing contracts, documents and state and federal law. I further understand that plan coverage and eligibility requirements may change from time to time pursuant to changes in collective bargaining agreements and state and federal law.
4. I understand that I will be required to provide documentation supporting the eligibility of any dependents upon enrollment and from time to time thereafter. I understand that if I do not provide these documents within the specified timeframe, my dependent(s) will not be enrolled in health benefits and cannot be added until the next annual open enrollment period or qualified Special Enrollee and/or qualifying life event.
5. I understand that I am required to notify the plan of any changes in dependent eligibility, such as divorce, which makes my dependent ineligible for benefits, within the timeframes set forth in the applicable Benefits Booklet and to provide required supporting documentation to my Human Resources or Payroll Representative. I understand that my dependent(s) will not be dis-enrolled from my health benefits nor offered COBRA until the documents are received by my Human Resources or Payroll Representative. Failure to notify my Human Resources or Payroll Representative in a timely manner could result in retroactive termination and recovery of claims which I may be responsible for paying.
6. Privacy Act Statement: The information you provide on this form is needed to document your enrollment in the State's Health Benefit Plan. This information will be shared with health benefit vendors, including medical and dental carriers. We request you provide your Social Security Number (SSN), as Section 1502(a) of Public Law 111-148 requires employers to collect Social Security Numbers (SSNs) of individuals who are covered on their health benefit plan. The State uses this SSN and other information on this form to file forms reporting employer-sponsored health coverage to the IRS. Providing your SSN is not mandatory. However, while the law does not require you to supply all the information on this form, failure to provide the requested information may result in the State's inability to promptly process your enrollment. The Privacy Act (5 U.S.C. 552a(b)), as amended, prohibits the disclosure of information obtained by the State of New Hampshire in a system of records to third parties, unless the beneficiary provides a written request or explicit written consent/authorization for a party to receive such information. Where the plan participant provides written consent/proof of representation, the State will permit authorized parties to access requisite information. By signing this form, you are allowing the State to provide requisite information to authorized parties.
7. I understand that furnishing any misleading, deceptive, incomplete, or untrue statement and/or committing fraud or misrepresentation against the plan may result in termination of benefits for myself and or my dependent(s) either prospectively or retroactively. Retroactive termination may result in recovery of claims paid on behalf of myself or my dependent(s).
8. The information I have furnished is, to the best of my knowledge and belief, correct and complete.

Employee Name (printed): _____

Employee Signature: _____

Date Signed: _____ **Employee ID:** _____

For Agency Benefit Representative Use Only:	Agency Name	Agency Benefit Representative Name	Contact #	Date Sent to DOP (if applicable)	Event Date	Benefit Effective Date:	NH FIRST Updated	
							Initials:	Date:
					Open Enrollment	1/1/2016		