NEW HAMPSHIRE AUTO DEALERS SERVICES, INC. – INSURANCE DIVISION

507 South Street• PO Box 2337 • Concord, NH 03302-2337
Telephone (603) 224-2369 • 800-852-3372 • Fax (603) 226-0898

Employee Application and Adjustment Form

NHADA USE ONLY
ACTION TAKEN:
EFFECTIVE DATE: _____
BY: ON: TWO CERTS ☐ RET ☐

PLEASE USE BLUE OR BLACK BALL POINT PEN OR TYPE

1

REASON FOR APPLICATION (CHECK APPROPRIATE BOXES)

☐ NEW
☐ ANNUAL OPEN ENROLLMENT
☐ CHANGE OF NAME / ADDRESS
☐ CHANGE IN STATUS
DATE OF EVENT: _____

CHANGE IN STATUS DUE TO:
☐ MARRIAGE
☐ BIRTH
☐ ADOPTION
☐ SPOUSE'S EMPLOYMENT CHANGE

☐ TRANSFER
☐ RETIREMENT
☐ DIVORCE
☐ LEGAL SEPARATION
☐ DEATH
☐ OTHER: _____

☐ DEPENDENT STUDENT NO LONGER ELIGIBLE
NAME _____
☐ DEPENDENT OVER AGE
NAME _____

2

EMPLOYEE INFORMATION

YOUR OCCUPATION _____
LAST NAME _____ FIRST NAME _____ MIDDLE INITIAL _____
SOCIAL SECURITY # _____ SEX: ☐ MALE ☐ FEMALE DATE OF BIRTH _____
MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ LEGALLY SEPARATED ☐ WIDOWED TELEPHONE # _____
MAILING ADDRESS _____ CITY _____ STATE ___ ZIP _____
EMPLOYER NAME _____ DATE OF HIRE _____ OR DATE OF REHIRE _____
EMPLOYER ADDRESS _____

3

DEPENDENT INFORMATION (LIST SPOUSE & ALL DEPENDENT CHILDREN)

LAST NAME	FIRST NAME	MIDDLE INITIAL	SEX	DATE OF BIRTH	RELATIONSHIP	SOCIAL SECURITY#

DENTAL NOTE: IF ENROLLING ONE ELIGIBLE DEPENDENT, ALL MUST BE ENROLLED. IF ENROLLING DEPENDENT CHILDREN OVER 19, PLEASE INDICATE IF DEPENDENT IS A STUDENT OR INCAPACITATED NEXT TO NAME.

(PLEASE ELECT ONLY BENEFITS AVAILABLE THROUGH YOUR GROUP. ALL COVERAGE SUBJECT TO EMPLOYER APPROVAL.)

4

DENTAL COVERAGE (DELTA DENTAL)

☐ SINGLE
☐ EMPLOYEE / SPOUSE
☐ EMPLOYEE / CHILD
☐ FAMILY
☐ REFUSE DENTAL
☐ VOLUNTARY CANCELLATION

(NHADA USE ONLY)

IS YOUR SPOUSE EMPLOYED? ☐ YES ☐ NO IF YES, EMPLOYER NAME _____
IF YOU ARE ELECTING DENTAL INSURANCE, WILL YOU OR ANY OTHER FAMILY MEMBER BE COVERED BY ANOTHER GROUP DENTAL PLAN?
☐ YES ☐ NO IF YES, NAME OF INSURANCE COMPANY

5

LIFE INSURANCE (ANTHEM LIFE)

OCCUPATION _____ EMPLOYEE CLASS _____ ANNUAL SALARY _____ HOURS WORKED WEEKLY _____
FULL NAME OF BENEFICIARY: (PRIMARY) _____ RELATIONSHIP _____
(CONTINGENT) _____ RELATIONSHIP _____

5A

LIFE INSURANCE
☐ ACCEPT ☐ REFUSE
☐ VOLUNTARY CANCELLATION

DEPENDENT LIFE
☐ ACCEPT ☐ REFUSE
☐ VOLUNTARY CANCELLATION

6

SHORT-TERM DISABILITY (ANTHEM LIFE)
☐ ELECT ☐ REFUSE ☐ VOLUNTARY CANCELLATION
(Options 1, 2, 4) WEEKLY SALARY $ _____
(Option 3) WEEKLY BENEFITS $ _____

VISION (VISION SERVICE PLAN)
☐ SINGLE
☐ EMPLOYEE / SPOUSE
☐ EMPLOYEE / 1 CHILD
☐ FAMILY
☐ REFUSE VISION
☐ VOLUNTARY CANCELLATION

7

If contributions are required under this Plan, I authorize my employer to deduct from my earnings until further notice my contributions for insurance under a policy held by NHADA. I understand that I may be subject to waiting periods or other restrictions if I enroll at a later date.

Signature of Employee _____ **Date** _____ **20** ____

DELTA DENTAL
Northeast Delta Dental

AnthemLife
Life and Disability
Anthem Life Insurance Company
An Independent licensee of the Blue Cross and Blue Shield Association.
® Registered marks of the Blue Cross and Blue Shield Association.

VSP Vision care for life

NHADA USE ONLY

Effective Dates: Dental _____ Life _____ STD _____ Vision _____
STD Employer Contribution % _____
STD Weekly Benefit _____

On completion, please sign and print this form, then fax it, attn to: Insurance Division; Fax No. 603-226-0898.