Allegiant Care
HEALTH BENEFITS FOR TEAMSTERS

P.O. Box 4604 • 800.258.9732
51 Goffstown Road • 603.669.4771
Manchester, NH 03108 • f 603.666.4477

Enrollment Form

Instructions:

1. **Complete, sign, and return this enrollment form along with any required supporting documentation as soon as possible to avoid delays in claims processing.**
2. **Be sure to provide social security numbers for members and all covered dependent(s).**
3. **If you and/or any dependent(s) had prior coverage that will be terminating, you must submit proof of cancellation or a HIPAA Notice indicating the date coverage ended.**

SELECT ALL THAT APPLY:

❒ New Member ❒ Add New Dependent ❒ Change Marital Status ❒ Change Name
❒ Reinstating ❒ Cobra Election ❒ Plan Change ❒ Other Insurance

Type of Dependent	Required Supporting Documentation
Spouse	❒ Copy of state-issued Marriage Certificate
Ex-Spouse	❒ Copy of Divorce Decree showing your responsibility for the ex-spouse's coverage (some plans do not provide for ex-spouse coverage)
Natural Child	❒ Copy of state-issued Birth Certificate (a birth notice is acceptable for newborns for the first 60 days; however, a state-issued Birth Certificate must be provided for continued coverage beyond 60 days)
Adopted Child	❒ Copy of state-issued Birth Certificate; AND ❒ Copy of Adoption Certificate/Documents
Step Child	❒ Copy of state-issued Birth Certificate; AND ❒ Copy of any applicable Divorce Decree or Support Order showing responsibility for the child's insurance coverage
Foster Child or Legal Dependent	❒ Copy of state-issued Birth Certificate: AND ❒ Copy of Legal Guardianship Documents

Once enrollment form and all supporting documentation have been submitted, please allow 7-10 business days for all aspects of enrollment to be completed, including the availability of ID Cards.

IMPORTANT: Dependents are pending until this form and ALL supporting documentation has been received.

Return your completed form to the mailing address noted above.
You may also fax it directly to 603-666-4477 or email enrollment@myallegiantcare.com.
Retain a copy of this form for your records.

SECTION 1: MEMBER INFORMATION

Member's Full Name		SSN	Sex ❑ M ❑ F
Date of Birth / /	Marital Status: ❑ Single ❑ Married ❑ Separated ❑ Divorced ❑ Widowed		
Mailing Address	City	State	Zip Code
Primary Phone ( )	E-mail Address		
Employer	Job Title	Local Union Number	
Date of Hire / /	Are you retired? ❑ Yes ❑ No	If yes, Date of Retirement: / /	

SECTION 2: SPOUSE/EX-SPOUSE INFORMATION (if no spouse, skip to Section 3)

Spouse's Full Name		SSN	Sex ❑ M ❑ F
Date of Birth / /	Date of Marriage / / (Must provide copy of state-issued Marriage Certificate)	Date of Divorce (if applicable) / / (Must provide copy of Divorce Decree)	
Mailing Address (if different)	City	State	Zip Code
Primary Phone ( )	E-mail Address		
Spouse's Employer		❑ Not Employed	

Does this spouse or ex-spouse have any other insurance coverage? ❑ Yes ❑ No (If yes, complete Section 5)

SECTION 3: OTHER DEPENDENT INFORMATION (if no other dependents, skip to Section 4)

1. Dependent's Full Name		SSN	Sex ❑ M ❑ F
Date of Birth / /	Relationship: ❑ Natural Child ❑ Step Child ❑ Adopted Child ❑ Other (specify)		
Does this dependent reside with you? ❑Yes ❑No	If no, name of parent/guardian with the whom child resides:		
Mailing Address (if different)	City	State	Zip Code

Does this dependent have other insurance through self or another guardian? ❑ Yes ❑ No (If yes, complete Section 5)

2. Dependent's Full Name		SSN	Sex ❑ M ❑ F
Date of Birth / /	Relationship: ❑ Natural Child ❑ Step Child ❑ Adopted Child ❑ Other (specify)		
Does this dependent reside with you? ❑Yes ❑No	If no, name of parent/guardian with the whom child resides:		
Mailing Address (if different)	City	State	Zip Code

Does this dependent have other insurance through self or another guardian? ❑ Yes ❑ No (If yes, complete Section 5)

SECTION 3: OTHER DEPENDENT INFORMATION (CONT.)

3. Dependent's Full Name	SSN	Sex ❑ M ❑ F
Date of Birth / /	Relationship: ❑ Natural Child ❑ Step Child ❑ Adopted Child ❑ Other (specify)	
Does this dependent reside with you? ❑Yes ❑No	If no, name of parent/guardian with the whom child resides:	
Mailing Address (if different)	City / State / Zip Code	
Does this dependent have other insurance through self or another guardian? ❑ Yes ❑ No (If yes, complete Section 5)		

4. Dependent's Full Name	SSN	Sex ❑ M ❑ F
Date of Birth / /	Relationship: ❑ Natural Child ❑ Step Child ❑ Adopted Child ❑ Other (specify)	
Does this dependent reside with you? ❑Yes ❑No	If no, name of parent/guardian with the whom child resides:	
Mailing Address (if different)	City / State / Zip Code	
Does this dependent have other insurance through self or another guardian? ❑ Yes ❑ No (If yes, complete Section 5)		

5. Dependent's Full Name	SSN	Sex ❑ M ❑ F
Date of Birth / /	Relationship: ❑ Natural Child ❑ Step Child ❑ Adopted Child ❑ Other (specify)	
Does this dependent reside with you? ❑Yes ❑No	If no, name of parent/guardian with the whom child resides:	
Mailing Address (if different)	City / State / Zip Code	
Does this dependent have other insurance through self or another guardian? ❑ Yes ❑ No (If yes, complete Section 5)		

*** Make copies of this page if you have more than 5 dependents. ***

SECTION 4: MEDICARE COVERAGE

Are you or any dependents (including spouse) enrolled in Medicare? ❑ Yes ❑ No (if no, skip to Section 5)

1. Name of Eligible Person	Reason for Eligibility ❑ Age 65+ ❑ Disability ❑ End Stage Renal Disease (ESRD)			
Type ❑ Part A	Effective Date / /	Type ❑ Part B	Effective Date / /	Provide a copy of Medicare ID card

2. Name of Eligible Person	Reason for Eligibility ❑ Age 65+ ❑ Disability ❑ End Stage Renal Disease (ESRD)			
Type ❑ Part A	Effective Date / /	Type ❑ Part B	Effective Date / /	Provide a copy of Medicare ID card

2. Name of Eligible Person	Reason for Eligibility ❑ Age 65+ ❑ Disability ❑ End Stage Renal Disease (ESRD)			
Type ❑ Part A	Effective Date / /	Type ❑ Part B	Effective Date / /	Provide a copy of Medicare ID card

SECTION 5: OTHER INSURANCE INFORMATION (List each insurance company separately)

Do you or any of your dependents have other medical, dental, prescription or vision insurance coverage (besides Medicare), including insurance prior to enrolling in this Plan? ❑Yes ❑No (If no, skip to Section 6)

1. Insurance Company Name		Effective Date / /
ID Number	Group Number	Expiration Date (if applicable) / /
Subscriber's Full Name		Subscriber's DOB / /
List ALL individuals besides the subscriber who are covered by this policy:		
Type of Coverage Provided by this Carrier (check all that apply) ❑ Medical ❑ Prescription ❑ Dental ❑ Vision		Is this a Medicaid, State Insurance or HealthCare.gov plan? ❑ Yes ❑ No

2. Insurance Company Name		Effective Date / /
ID Number	Group Number	Expiration Date (if applicable) / /
Subscriber's Full Name		Subscriber's DOB / /
List ALL individuals besides the subscriber who are covered by this policy:		
Type of Coverage Provided by this Carrier (check all that apply) ❑ Medical ❑ Prescription ❑ Dental ❑ Vision		Is this a Medicaid, State Insurance or HealthCare.gov plan? ❑ Yes ❑ No

3. Insurance Company Name		Effective Date / /
ID Number	Group Number	Expiration Date (if applicable) / /
Subscriber's Full Name		Subscriber's DOB / /
List ALL individuals besides the subscriber who are covered by this policy:		
Type of Coverage Provided by this Carrier (check all that apply) ❑ Medical ❑ Prescription ❑ Dental ❑ Vision		Is this a Medicaid, State Insurance or HealthCare.gov plan? ❑ Yes ❑ No

***** If you and/or any dependent(s) had prior coverage that will be terminating, you must submit proof of cancellation or HIPAA Notice indicating date coverage ended*****

SECTION 6: CERTIFICATION

I certify that I am the subscribing member and all of the information provided on this form is complete and accurate. I understand it is a crime to knowingly provide false, incomplete or misleading information to obtain insurance or benefit coverage for the purpose of defrauding the Plan or insurance carrier. Penalties may include imprisonment, fines and/or denial of insurance benefits.

I understand I may not make any changes until Open Enrollment unless I have an approved Qualifying Event (*i.e.*, marriage, birth, adoption, divorce, change of employment or loss/gain of other insurance) and notify Allegiant Care within 30 DAYS of such an event. I understand I must also notify my employer if there is a change in my dependent status.

I understand all benefits are subject to conditions stated in the Plan document. I understand that Allegiant Care requires additional documentation, if applicable, before any dependent(s) are enrolled on my Plan.

Member Signature: _____ **Date:** _____