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

REASON FOR APPLICATION (CHECK APPROPRIATE BOXES)

1

■ 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 _____

EMPLOYEE INFORMATION

2

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 _____

DEPENDENT INFORMATION (LIST SPOUSE & ALL DEPENDENT CHILDREN)

3

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.)

DENTAL COVERAGE (DELTA DENTAL)

4

■ 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

LIFE INSURANCE (ANTHEM LIFE)

5

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

LIFE INSURANCE

5A

■ ACCEPT ■ REFUSE
■ VOLUNTARY CANCELLATION

DEPENDENT LIFE

■ ACCEPT ■ REFUSE
■ VOLUNTARY CANCELLATION

SHORT-TERM DISABILITY (ANTHEM LIFE)

6

■ 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.