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ANNUITY DEDUCTION AUTHORIZATION FOR MEDICAL AND DENTAL BENEFITS

FOR NHRS RETIREES WITH MEDICAL AND/OR DENTAL COVERAGE THROUGH HEALTHTRUST

SECTION I – INSTRUCTIONS

This form is to be used by Retirees of HealthTrust Member Groups and any surviving spouse or child who is entitled to receive a benefit from NHRS (each, a "Beneficiary") to authorize the deduction of medical and/or dental coverage contribution(s) from the Beneficiary's monthly NHRS annuity payments. It may also be used to provide information about Beneficiaries entitled to the Medical Subsidy even if they do not receive an annuity payment. If a Retiree and his or her spouse are both receiving a retirement annuity from NHRS and will be covered under the medical/dental plan of only one of their former employers, then submit one form for both Retirees signed by the Retiree who is the policyholder. If a Retiree and his or her spouse are both receiving a retirement annuity from NHRS and will be covered separately under the medical/dental plans of the former employers of each Retiree, then submit a form for each Retiree.

- **The Beneficiary must complete sections II and V and return the form to the former employer or HealthTrust**
- **The former employer must complete sections III and IV and submit the form to HealthTrust**
- **This is a two-page form – please complete both pages – incomplete forms will be returned and may result in a delay in processing. Please type or print all entries**

SECTION II – RETIREE/BENEFICIARY INFORMATION *(To be completed by Retiree/Beneficiary)*

Retiree/Beneficiary Name *(Last, First, MI)*:	DOB:	SSN:
Marital Status ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Legally Separated		
Retiree's Spouse Name*(Last, First, MI)*:	DOB:	SSN:
Retiree/Beneficiary Mailing Address *(PO/Street, City, State, Zip)*:		
Telephone Number: ( )	Email Address:	
Retired as: ☐ Employee ☐ Teacher ☐ Police ☐ Fire	Beneficiary is ☐ Member ☐ Surviving Spouse ☐ Surviving Child	

SECTION III – FORMER EMPLOYER INFORMATION *(To be completed by former employer or HealthTrust)*

Employer Name:	Telephone Number: ( )
Medical Group #: Retiree: Spouse: Dependent Child:	
Dental Group #:	HT #:

SECTION IV – CONTRIBUTION DEDUCTION INFORMATION *(To be completed by former employer or HealthTrust)*

Effective Date of Request:	**Requested Action:** New, Change, No Change, Cancel, Subsidy Only (Please circle)	
1. Retiree/Beneficiary Medical Plan Rate	$	
2. Spouse Medical Plan Rate	$	
3. Dental Plan Rate (if applicable)	$	
4. Dependent Children Medical Plan Rate	$	
5. Total Monthly Rate (line 1 + line 2 + line 3 + line 4)	$	
6. Expected Medical Subsidy (if applicable)	$	
7. Retirement Annuity Deduction (line 5 minus line 6)	$	

SECTION IVa – CONTRIBUTION ALLOCATION *(To be completed by HealthTrust Groups that have Retiree Billing Services)*

	Group Pays	NHRS Subsidy	Additional Deduction	Retiree Pays	TOTAL
MEDICAL			100%NHRS		
DENTAL					

Form is continued on reverse side

SECTION V - PLEASE READ, SIGN, AND DATE BELOW *(To be completed by Retiree/Beneficiary)*

LIFE EVENTS

If you are qualified for a NHRS Medical Subsidy, you must notify HealthTrust or NHRS within 30 days if any of the following events occur:

- Any change in marital status of the Retiree or surviving Beneficiary;
- The death of the Retiree or any Beneficiary;
- The remarriage of a surviving spouse of a deceased Retiree or deceased NHRS Member;
- A qualified certifiably dependent disabled child no longer resides in the household;
- A surviving spouse of a Member who died in the line of duty remarries or becomes eligible to receive medical insurance or health coverage from any other employer-sponsored plan (even if the individual declines to enroll in such plan); or
- The attainment of 18 years of age (23 if a full-time student) by the surviving child of an NHRS Member who died in the line of duty or if such child becomes eligible to receive medical insurance or health coverage from any other employer-sponsored plan (even if the individual declines to enroll in such plan).

ENTITLEMENT TO MEDICARE

The amount of the Medical Subsidy is reduced when a qualified person becomes "entitled to Medicare". The reduction applies to entitlement to either Part A coverage (hospitalization) or Part B coverage (supplementary medical insurance) regardless of whether the entitled individual actually enrolls or pays for such coverage. Every Beneficiary is required to notify NHRS within 30 days of when any person qualified for a Medical Subsidy becomes entitled to Medicare because of attaining age 65 or because of the receipt of Social Security disability benefits (generally after receiving Social Security disability benefits for 24 months).

Are you entitled to Medicare at this time?	YES: ☐	NO: ☐
Is your spouse entitled to Medicare at this time?	YES: ☐	NO: ☐
Is your dependent disabled child entitled to Medicare a this time?	YES: ☐	NO: ☐

CERTIFICATION AND SIGNATURE

I hereby authorize NHRS to deduct from my monthly retirement annuity the amount of monthly contributions I owe with respect to my coverage under the medical and/or dental plan of the former employer named above. The initial amount of such deduction is provided above in Section IV. This authorization shall apply, without further notice to me, to any change in the amount to be deducted because of (a) any change in contribution costs or changes in coverage under the former employer's plan or (b) any change in the amount of any Medical Subsidy for which I, my spouse or my children are qualified pursuant to RSA 100-A:50-55. I understand that eligibility for the Medical Subsidy is conditioned upon my being covered under the medical plan of the former employer named above.

If it is determined by NHRS that I qualify for the Medical Subsidy, all amounts payable on behalf of me, my spouse and any qualified child will be paid directly to HealthTrust and will be applied on my behalf to reduce the amount of contribution I owe each month. The balance of the contribution due from the Beneficiary as determined by the employer, if any, will be deducted from my monthly retirement annuity effective as of the first of the month following attainment of Medical Subsidy eligibility.

Change in Eligibility Status: I understand that the amount of Medical Subsidy for which I am qualified may change due to a change in life events described above or entitlement to Medicare as provided in RSA 100-A:50-55. I hereby agree to notify HealthTrust and NHRS within 30 days following the occurrence of any of the Life Events listed above or if I, my spouse or any qualified child becomes entitled to Medicare. In this regard, I hereby certify that I have read and understand the information provided above which describes when I am required to notify HealthTrust and NHRS. I also agree to complete and timely file an annual NHRS Eligibility Questionnaire regarding my eligibility for the Medical Subsidy.

I understand that NHRS reserves the right to recover all Medical Subsidy amounts paid on behalf of me, my spouse or former spouse, or any qualified child who has lost Medical Subsidy eligibility, and/or all overpayments resulting from my failure to report entitlement to Medicare or the occurrence of any of the Life Events as described above. I further understand that I am ultimately responsible for repayment to my former employer of any such overpayments recovered by NHRS from HealthTrust.

I hereby attest, under penalties of perjury, that the information provided above is true to the best of my knowledge and belief.

Retiree/ Beneficiary Signature:	Date:
Spouse Signature:	Date:

SECTION VI – FOR NHRS USE ONLY

Med Sub: ☐ Yes ☐ No	Payroll Date:	Process Date:	Initials: