



## LIFE, LONG-TERM DISABILITY (LTD), AND/OR SHORT-TERM DISABILITY (STD) APPLICATION AND CHANGE FORM

**WELCOME TO LGC HEALTHTRUST**

Use this form to change your beneficiary(ies) as well as to enroll in or change your disability and/or life insurance coverage. Be sure to complete this entire form and retain the PINK copy. If you only need to change your mailing address, do not complete this form; instead, call New Hampshire Local Government Center (LGC) HealthTrust's Member Services Department at 800.527.5001 and notify your employer.

**BE SURE TO FILL OUT EACH SECTION COMPLETELY.** Failure to complete each section in full could delay the start of coverage.

**HOW TO COMPLETE THIS FORM**

**Remove this cover sheet before you begin.**

STEP <b>1</b>	<p><b>SUBSCRIBER (EMPLOYEE) INFORMATION</b> Complete this section with your personal information, using your full legal name. Select the type of LGC HealthTrust-sponsored disability and/or life coverage you are requesting. Please limit your selection to only those coverages offered by your employer and for which you are eligible.</p> <p>Some disability and life coverages may require evidence of insurability. You will not be eligible for any amount greater than the evidence of insurability requirement if you do not submit an <i>Evidence of Insurability</i> form; this form may be obtained from your employer or LGC HealthTrust. You will be added for an amount greater than the evidence of insurability requirement once approved. For more information, refer to your certificate of coverage.</p>
STEP <b>2</b>	<p><b>REASON FOR COMPLETING APPLICATION</b> Use this section to indicate the reason(s) for completing form.</p>
STEP <b>3</b>	<p><b>BENEFICIARY INFORMATION</b> Please name your beneficiary(ies) for your disability and/or life coverages. If you wish to name a different beneficiary(ies) for your short-term disability (STD), long-term disability (LTD), and/or life coverages, attach a separate piece of paper containing all necessary information. Otherwise, your beneficiary(ies) will be the same for all coverages.</p> <p>You may name more than one beneficiary(ies). If you specify benefit percentages, the total must equal 100 percent. If you do not specify benefit percentages, benefits will be paid in equal shares.</p> <p>If you do not name a beneficiary(ies) – or if neither your primary nor contingent beneficiary(ies) survive you – benefits will be paid in order of survivorship shown in your certificate of coverage. Your primary beneficiary(ies) are the person(s) you name to receive benefits. Your contingent beneficiary(ies) are the person(s) you name to receive benefits if your primary beneficiary(ies) do not survive you.</p>
STEP <b>4</b>	<p><b>SUBSCRIBER SIGNATURE</b> Sign and date this form; return completed form to your employer (retain the pink copy for your records).</p>
STEP <b>5</b>	<p><b>EMPLOYER USE ONLY</b> Employer must complete this section and forward to LGC HealthTrust for processing at: PO Box 617, Concord, NH 03302.</p>

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## SUBSCRIBER (EMPLOYEE) INFORMATION

STEP 1	Last Name		First Name		MI
	Social Security #		Date of Birth		Gender Male Female
	Mailing Address				Telephone ( )
	City		State		Zip
	Is your position covered by a collective bargaining agreement? Yes No If yes, check the appropriate category: Teacher Police Fire Public Works Other				Employer Name
STEP 1	<b>Marital Status</b>		<b>TYPE OF COVERAGE AND MEMBERSHIP REQUESTED (check)</b>		
	<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Civil Union Partnership <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced/Legally Separated		<b>Life Insurance</b> <input type="checkbox"/> Basic Life <input type="checkbox"/> Supplemental Life <input type="checkbox"/> Dependent Life	<b>Disability Insurance</b> <input type="checkbox"/> Long-Term Disability <input type="checkbox"/> Short-Term Disability	

<b>LGC HealthTrust Office Use Only</b>	
STEP 2	<b>REASON FOR COMPLETING FORM</b>
	<input type="checkbox"/> New Subscriber <input type="checkbox"/> Name Change <input type="checkbox"/> Change in Beneficiary ONLY <input type="checkbox"/> Benefit Change

## BENEFICIARY INFORMATION

STEP 3	Name of Beneficiary	Date of Birth	Relation to Subscriber	Social Security #	Benefit Percentage
	Primary Beneficiary	___/___/___		- -	%
	Primary Beneficiary	___/___/___		- -	%
	Primary Beneficiary	___/___/___		- -	%
					Total: 100%
	Contingent Beneficiary	___/___/___		- -	%
Contingent Beneficiary	___/___/___		- -	%	
				Total: 100%	

## SUBSCRIBER SIGNATURE

STEP 4	I hereby authorize LGC HealthTrust and my employer to institute the action(s) indicated on this form. If my employer requires a contribution for this coverage, this authorized the appropriate payroll deductions. I understand that the effective date and termination date of my membership will be determined by LGC HealthTrust and my employer in accordance with the plan rules. I understand that I must sign this form for claims to be processed and beneficiary designation(s) to be made valid. By signing this application, I attest to the accuracy and truthfulness of this information and will provide documentation to LGC HealthTrust upon request.
	<b>Subscriber Signature</b> _____ Date ___/___/___

## EMPLOYER USE ONLY

STEP 5	Date of Hire ___/___/___	Date of Rehire ___/___/___	Eligibility Organization Name		
	Full-Time Number of Hours	Part-Time Number of Hours	Annual Salary	Employee Job Title	
	<b>Life Coverage</b>		<b>Long-Term Disability Coverage</b>		<b>Short-Term Disability Coverage</b>
	Class Number		Class Number		Class Number
	Effective Date of Coverage		Effective Date of Coverage		Effective Date of Coverage
	Base Life Benefit Amount		Benefit Administrator Signature/Stamp		
Supplemental Life Benefit Amount					