HealthTrust

RETIREMENT ANNUITY DEDUCTION AUTHORIZATION FOR MEDICAL AND DENTAL BENEFITS

P.O. BOX 617 • CONCORD, NH 03302-0617 • 800.527.5001 • FAX 603.226.2988 • WWW.HEALTHTRUSTNH.ORG

Effective Date_____

Retiree's Name _____ Social Security # _____ DOB _____

Marital Status: ❑ Single ❑ Married ❑ Widowed ❑ Divorced ❑ Legally Separated

Spouse's Name _____ Social Security # _____ DOB _____

Address _____

Telephone #_____

Employer Name_____

Retiree Medical Group # _____

Spouse Medical Group #_____

Dental Group # _____

HT #_____

	Current Monthly rate as of Enrollment		
	Retiree	Spouse	Incapacitated Dependent
Medical Plan	$	$	$
Less Subsidy Amt.	$	$	$
Subtotal	$		
Dental Plan	$		
Total Deduction	$		

Please read and initial one:

____ **Group I – Employee and Teacher**

I understand that the amount of the deduction hereby authorized to be made from my monthly retirement benefit payment shall be the Total Monthly Rate less any subsidy benefits to which I may be entitled. This amount may increase or decrease without further notice to me as costs of my coverage changes and I hereby authorize said additional amounts to be deducted.

____ **Group II – Fire and Police**

I understand that the amount of the deduction hereby authorized to be made from my monthly retirement benefit payment shall be the Total Monthly Rate less any subsidy benefits to which I may be entitled. This amount may increase or decrease without further notice to me as costs of my coverage changes and I hereby authorize said additional amounts to be deducted.

To be Completed by Groups that Have Elected HealthTrust's Retiree Billing Services		
	MEDICAL	DENTAL
Group Pays:		
NHRS Subsidy:		
NHRS Additional Deduction:		
Member Pays:		
TOTAL:		

If it is determined by the NHRS that I qualify for the medical coverage subsidy benefit pursuant to RSA 100-A:50-55, said subsidy amount will be applied to my medical coverage contribution. Any remaining amount due after the application of the subsidy benefit will be deducted from my monthly retirement benefit payment.

Change in Membership Status: If I become divorced I understand that I must notify my former employer of the change in my eligibility status for the medical subsidy and that the New Hampshire Retirement System reserves the right to recover any subsidy amounts paid on behalf of a divorced spouse.

Member/Policy Holder Signature_____ Date _____

Spouse Signature _____ Date _____

WHITE – HEALTHTRUST YELLOW – HEALTHTRUST PINK – EMPLOYER GOLDENROD – EMPLOYEE

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