

SMALL GROUP COVERAGE

Employee enrollment and change form



An Independent Licensee of
the Blue Cross and Blue Shield Association.

Submit one of three ways: email, fax, or mail, see page 2.
Please provide all information and print in ink or type.

Requested effective date

Section 1: EMPLOYEE INFORMATION

| | | | |
|---|---|--|----------------------|
| Employer Group name: | | Standard Plans: <input type="checkbox"/> Platinum <input type="checkbox"/> Gold <input type="checkbox"/> Silver Reflective <input type="checkbox"/> Bronze <input type="checkbox"/> Bronze without Rx MOOP <input type="checkbox"/> Silver CDHP Reflective <input type="checkbox"/> Bronze CDHP | |
| Group Number/Division: | | Vermont Preferred Plans: <input type="checkbox"/> Vermont Preferred Gold <input type="checkbox"/> Vermont Preferred Silver Reflective <input type="checkbox"/> Vermont Preferred Bronze | |
| | | Vermont Select Plans: <input type="checkbox"/> Vermont Select CDHP Gold <input type="checkbox"/> Vermont Select CDHP Silver Reflective <input type="checkbox"/> Vermont Select CDHP Bronze | |
| Last name: | First name: | Social Security Number (SSN) ¹ : | Date of birth (DOB): |
| Physical address: | City: | State: | Zip code: |
| Mailing address: | City: | State: | Zip code: |
| Phone number: | Email address: | Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female | |
| Primary Care Provider (Pcp) name, or npi number ³ | Marital status: <input type="checkbox"/> Single <input type="checkbox"/> Domestic Partner ² <input type="checkbox"/> Married/party to a civil union | Employment status: <input type="checkbox"/> Active <input type="checkbox"/> Retired <input type="checkbox"/> Continuation | |
| Are you a current patient? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| Health coverage type: <input type="checkbox"/> Employee only <input type="checkbox"/> Employee & spouse (including party to a civil union/domestic partner) <input type="checkbox"/> Employee & children <input type="checkbox"/> Family | | | |

Section 2: NEW ENROLLMENT (Check one, then go to SECTION 4)

New group Open enrollment New hire/re-hire Continuation of coverage (COBRA/VIPER) Spouse turning age 65
 Special Enrollment Period (SEP) **please indicate qualifying event in Section 3** Transferred from another BCBSVT plan
 Transferring from certificate no. _____

Section 3: CHANGE/CANCELLATION

| | |
|---|---|
| CHANGE: (including SEP qualifying events) Effective date ___/___/___ <input type="checkbox"/> Pregnancy <input type="checkbox"/> Birth <input type="checkbox"/> Adoption placement date ___/___/___ <input type="checkbox"/> Marriage/Civil Union <input type="checkbox"/> Divorce <input type="checkbox"/> Address change <input type="checkbox"/> Name change <input type="checkbox"/> PCP change <input type="checkbox"/> Court ordered change ² <input type="checkbox"/> Loss of coverage ² | CANCEL: Date of cancellation ___/___/___ <input type="checkbox"/> Voluntary cancel (signature required) _____ <input type="checkbox"/> Left employment (group benefits administrator signature) _____ Other (explain) _____ |
|---|---|

Please see section 6 on page 2 for subscriber signature

Section 4: LIST ALL DEPENDENTS BELOW TO BE ADDED OR REMOVED

Dependent Information

Important note: federal law mandates our collection of SSN for all members.¹

Primary Care Provider (PCP) Information³

Add Remove

Spouse/party to a civil union/domestic partner

SSN¹

Sex

PCP Name:

DOB

Male

NPI No.³

Female

Are you a current patient? Yes No

Last name:

First name:

Add Remove

Child or incapacitated dependent 26 & older²

SSN¹

Sex

PCP Name:

DOB

Male

NPI No.³

Female

Are you a current patient? Yes No

Last name:

First name:

Add Remove

Child or incapacitated dependent 26 & older²

SSN¹

Sex

PCP Name:

DOB

Male

NPI No.³

Female

Are you a current patient? Yes No

Last name:

First name:

Add Remove

Child or incapacitated dependent 26 & older²

SSN¹

Sex

PCP Name:

DOB

Male

NPI No.³

Female

Are you a current patient? Yes No

Last name:

First name:

Section 5: OTHER INSURANCE INFORMATION

If you obtain health insurance coverage with us, will you or any of your dependents be covered with another health or dental insurance plan (including Medicare or Medicaid)? Yes (please complete the applicable section below) No

| MEDICAL | | | DENTAL | | |
|--------------------------------------|---|-----------|--------------------------------------|---|-----------|
| Insurance company (name and address) | | | Insurance company (name and address) | | |
| Policyholder name | Policy certificate no. | Group no. | Policyholder name | Policy certificate no. | Group no. |
| Effective date ___/___/___ | Type of coverage <input type="checkbox"/> 1-person <input type="checkbox"/> 2-person <input type="checkbox"/> Family | | Effective date ___/___/___ | Type of coverage <input type="checkbox"/> 1-person <input type="checkbox"/> 2-person <input type="checkbox"/> Family | |

Section 6: SUBSCRIBER SIGNATURE

I certify that the statements on this application and all information I've furnished is true and complete to the best of my knowledge. I authorize any health care provider to disclose to Blue Cross and Blue Shield of Vermont, or its designated agent, any information acquired in connection with my past or future care or treatment or that of any dependent named herein or hereafter added to my coverage. I understand that no right whatsoever is created by this application and that the same shall not be considered accepted unless and until the contract is actually issued by Blue Cross and Blue Shield of Vermont.

I UNDERSTAND THAT MY BENEFITS ARE GOVERNED BY THE PROVISIONS OF MY CERTIFICATE AND OUTLINE OF COVERAGE.

SIGN HERE

► Employee signature _____ Date _____ ◀

If you are applying for coverage on behalf of another person other than your dependent, that person will need to complete an authorization form.

Submit one of three ways:

Email:
asinbox@bcsvt.com

Fax:
(802) 371-3329

Mail:
Blue Cross Blue Shield of Vermont
P.O. Box 186
Montpelier, VT 05601-0186

If you are adding a dependent child, 26 or older, contact customer service at (800) 247-2583 for further instructions.

¹SSN required all members (Federal mandate requires the collection of SSN)

²Additional documentation required

³See our "Find-a-Doctor" tool at www.bcsvt.com/findadoctor