SMALL GROUP COVERAGE

Employee enrollment and change form



Requested effective date

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

Section 1: EMPLOYEE INFORMATION							
Employer Group name:	Standard Plans: □ Platinum □ Gold □ Silver Reflective □ Bronze □ Bronze Integrated □ Silver CDHP Reflective □ Bronze CDHP						
Group Number/Division:		Vermont Preferred Vermont Select Pla	d Gold Vermont Preferred Silver d d Bronze Ins: old CDHP Vermont Select Silver (
Last name:	First nan	ne:	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: 🗖 Male 🗖 Female				
Primary Care Provider (Pcp) name, or npi number Are you a current patient?	nber ³ Marital status: Single Domestic Partner ² Married/party to a civil union		Employment status: Active Retired Continuation				
Health coverage type:							
Employee only Employee & spouse (in	ncluding part	ty to a civil union/domes	stic partner) 🗖 Employee & Child	or Children 🗖 Family			
Section 2: NEW ENROLLMENT (Check one							
 New group Open enrollment New hire/re-hire Continuation of coverage (COBRA/VIPER) Spouse turning age 65 Special Enrollment Period (SEP) <i>please indicate qualifying event in Section 3</i> Transferred from another BCBSVT plan Transferred from another BCBSVT plan, Member ID 							
Section 3: CHANGE/CANCELLATION							
CHANGE: (including SEP qualifying events) Marriage/Civil Union Effective date/_/ Divorce Pregnancy Address change Birth Name change Adoption placement date PCP change _// Court ordered change² Loss of coverage² Divorce		ange ge e ed change ²	CANCEL: Date of cancellation/ Voluntary cancel (signature required) Left employment (group benefits administrator signature)				
		e section 6 on page 2 fo	Other (explain)				

Dependent Information Primary Care Provider (PCP) Information* Important note: refers. Jaw mandates our collection of SN. for all members.* Primary Care Provider (PCP) Information* Add Renve SSN* Sax PCP Name: Souse/party to a civit unon/domestic partner DCB Main NPI No ² Add Renve First name: PCP Name: NPI No ² Add Renve SSN* Sax PCP Name: No Add Renve First name: DCB Maie NPI No ³ Add Renve First name: DCB Maie NPI No ³ Add Renve SSN* Sax PCP Name: No Add Renve DCB Maie NPI No ³ Are you a current patient? Yes No Add Renve First name: First name: PCP Name: No No Are you a current patient? Yes No Induction Medicare of Medical? DCB Maie NPI No ³ Are you a current patient? Yes No Induction Medicare of Medical? No Sexion St OtHER INSURANCE	Sec	tion 4: LIST ALL DE	PENDENTS BELOW TO	BE ADDED OR REMOVE	D			
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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.bcbsvt.com/findadoctor**