INDIVIDUAL & FAMILY COVERAGE

Direct-Enrollment & change form

BlueCross BlueShield of Vermont
An Independent Licensee of the Blue Cross and Blue Shield Association.

Submit one of three ways: email, fax, or mail, see page 3.
Please provide all information and print in ink or type.

Requested effective date
/ /

Section 1: INFORMATION

Last name:	First name:	Social Security number[1] (SSN):	
Date of birth (DOB):	Sex: ☐ Male ☐ Female	Marital status: ☐ Single ☐ Married/party to a civil union	
Phone number: Cell phone (optional):	Email address:	Primary Care Provider (PCP) name, or NPI number[3]: Are you a current patient? ☐ Yes ☐ No	
Physical address:	City:	State:	ZIP code:
Mailing address:	City:	State:	ZIP code:

Standard Plans:
☐ Platinum ☐ Gold ☐ Silver Reflective ☐ Bronze ☐ Bronze Integrated ☐ Silver CDHP Reflective ☐ Bronze CDHP

Vermont Preferred Plans:
☐ Vermont Preferred Gold ☐ Vermont Preferred Silver Reflective ☐ Vermont Preferred Bronze

Vermont Select Plans:
☐ Vermont Select Gold CDHP ☐ Vermont Select Silver CDHP Reflective ☐ Vermont Select Bronze CDHP

☐ Catastrophic *(must be under age 30 to apply)*

Membership type:
☐ Individual only ☐ Individual & spouse (including party to a civil union) ☐ Individual & child or children ☐ Child only (under 18) ☐ Family

Section 2: NEW ENROLLMENT

☐ New enrollment ☐ Open enrollment ☐ Spouse turning age 65 ☐ Special Enrollment Period (SEP) ***please indicate qualifying event in Section 3***

☐ Transferred from another Blue Cross VT plan, Member ID # _____

Please see section 8 on page 2 for subscriber signature

Section 3: CHANGE/CANCELLATION

CHANGE:
(including SEP qualifying events)

Effective date ___/___/____

☐ Pregnancy
☐ Birth
☐ Adoption
placement date ___/___/____

☐ Income change
☐ Marriage
☐ Divorce/dissolution of Civil Union
☐ Court ordered change[2]
☐ Loss of coverage[2]

Other changes:

☐ Name change
☐ New Vermont resident
date of move ___/___/____
☐ Address change

CANCEL:
Date of cancellation ___/___/____

☐ Voluntary cancel
(please sign Section 8)
☐ Other (explain)

____
____
____
____

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) Information[3]
☐ Add ☐ Remove Spouse/party to a civil union Last name: First name:	SSN[1] DOB	Sex ☐ Male ☐ Female	PCP Name: NPI No.[3] Are you a current patient? ☐ Yes ☐ No
☐ Add ☐ Remove Child or incapacitated dependent 26 & older[2] Last name: First name:	SSN[1] DOB	Sex ☐ Male ☐ Female	PCP Name: NPI No.[3] Are you a current patient? ☐ Yes ☐ No
☐ Add ☐ Remove Child or incapacitated dependent 26 & older[2] Last name: First name:	SSN[1] DOB	Sex ☐ Male ☐ Female	PCP Name: NPI No.[3] Are you a current patient? ☐ Yes ☐ No
☐ Add ☐ Remove Child or incapacitated dependent 26 & older[2] Last name: First name:	SSN[1] DOB	Sex ☐ Male ☐ Female	PCP Name: NPI No.[3] Are you a current patient? ☐ Yes ☐ No
☐ Add ☐ Remove Child or incapacitated dependent 26 & older[2] Last name: First name:	SSN[1] DOB	Sex ☐ Male ☐ Female	PCP Name: NPI No.[3] Are you a current patient? ☐ Yes ☐ No
☐ Add ☐ Remove Child or incapacitated dependent 26 & older[2] Last name: First name:	SSN[1] DOB	Sex ☐ Male ☐ Female	PCP Name: NPI No.[3] Are you a current patient? ☐ Yes ☐ No

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

Insurance company (name and address)		
Policyholder name	Policy certificate no.	Group no.
Effective date ___/___/____	Type of coverage ☐ 1-person ☐ 2-person ☐ Family	

DENTAL

Insurance company (name and address)		
Policyholder name	Policy certificate no.	Group no.
Effective date ___/___/____	Type of coverage ☐ 1-person ☐ 2-person ☐ Family	

Section 6: AMERICAN INDIAN[4] OR ALASKA NATIVE FAMILY MEMBER(S)

Are you or anyone in your family an American Indian[4] with a federally recognized tribe or an Alaska Native? ☐ Yes (see Section 7) ☐ No

Please be aware, if you decide to direct enroll through us you will be ineligible to take advantage of any cost-sharing reduction (CSR) plans. If you would like to take advantage of a CSR plan offering, you will need to enroll through Vermont Health Connect..

[4]Please note that we are using this term rather than Native American because this is the term used in the federal law.

Section 7: ACKNOWLEDGEMENT OF INELIGIBLITY FOR SUBSIDIES

If you are not eligible for subsidies (like Federal premium assistance, premium tax credits, reduced cost-sharing plans or Vermont premium assistance) or choose not to take advantage of them, you can enroll directly with Blue Cross and Blue Shield of Vermont for coverage beginning 2023. This means that, for 2023 coverage, you will be working directly with us for enrollment, getting bills, paying premiums and reporting changes to your membership.

By completing this form, you signify your desire to move your current enrollment from Vermont Health Connect to Blue Cross and Blue Shield of Vermont for coverage beginning January 1, 2023. If your circumstances have changed since last year, please use the Vermont Health Connect plan comparison tool (**www.vermonthealthconnect.gov**) to be sure you're not newly eligible for premium assistance before proceeding. Once you direct enroll with us, you cannot enroll through Vermont Health Connect unless you experience a Special Enrollment Period (SEP) qualifying life event.

By checking the box below, I confirm that I am the subscriber/policy holder in my household and authorized to make this decision. I understand that if I enroll directly with Blue Cross and Blue Shield of Vermont, I give up my right to subsidies. I authorize Blue Cross and Blue Shield of Vermont to submit a cancellation to Vermont Health Connect on my behalf for 2023 coverage, since I am enrolling directly with Blue Cross and Blue Shield of Vermont.

▶ ☐ Yes, I understand.

Section 8: 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 acknowledge my ineligiblity for any subsidies. 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, OUTLINE OF COVERAGE and other elements of my contract.

SIGN HERE

▶ 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@bcbsvt.com**	**Fax:** (802) 371-3329	**Mail:** (please include the first month's premium) Blue Cross and Blue Shield of Vermont P.O. Box 186 Montpelier, VT 05601-0186
Please mail the first month's premium to Blue Cross and Blue Shield of Vermont. We must receive payment before coverage can start.		

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

[1] SSN required for all members (federal mandate requires the collection of SSN)

[2] Additional documentation required

[3] See our Find a Doctor tool at **bluecrossvt.org/find-doctor**

[4] Please note that we are using this term rather than Native American because this is the term used in the federal law.