NEW SMALL GROUP CHECKLIST

For Small Group Qualified Health Plans (QHP)

BlueCross BlueShield of Vermont

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

☑ **Please return the following items to Blue Cross® and Blue Shield® of Vermont for a new small group enrollment.**

Required Documentation List:

- ☐ Completed **Small Group Enrollment Agreement** form
- ☐ Completed **Small Group Certification** form
- ☐ Completed **Employee Census Information** form
- ☐ Completed **2025 Coverage Election** form
- ☐ Completed **Small Group Coverage Employee Enrollment and Change Form** for each employee enrolling in the group plan.

Important Note:

Each employee and their dependent(s) must select a participating Primary Care Physician (Nurse Practitioners, Physician's Assistants, Specialists and facilities are NOT acceptable).

☐ **Provide proof of business:**

IF YOU HAVE ...	PROVIDE ...
...filed business taxes	■ Vermont Quarterly Wage Report (C-101)
...NOT filed business taxes	■ Most recent payroll register OR ■ Letter Indicating the official start date of your business AND a copy of your state of Vermont Trade Name Registration form OR ■ Certificate of Authority form

Next Steps:

- ☐ Enrollees can complete a **Continuity of Care** form if they are being treated for a life threatening/disabling degenerative condition, are in their second or third trimester of pregnancy, have an upcoming surgery OR are on a medication for which prior approval has been given by the previous carrier.
- ☐ Employers must proivde a copy of the Summary of Benefits and Coverage (SBC) to all eligible employees 30 days prior to effective date or within seven days of election of new coverage. To obtain a copy of your SBC, contact our Consumer & Business Support Services team at (800) 255-4550 (TTY/TDD: 711) or email **consumersupport@bcbsvt.com**. SBC's can also be found on our website at **bluecrossvt.org/smallbusiness**.
- ☐ A check for your first month's premium, made payable to Blue Cross and Blue Shield of Vermont.

Mail to: Blue Cross and Blue Shield of Vermont
PO BOX 186
Montpelier, VT 05601-0186

SMALL GROUP ENROLLMENT AGREEMENT

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

For Small Group Qualified Health Plans (QHP)

Please complete this form in its entirety, otherwise it will be returned to you.

Section 1: GROUP INFORMATION

Legal Business or Organization Name	**Requested Effective Date**	
DBA name (if applicable)	Federal Tax ID (required)	
Nature of Business or Organization	Four-Digit SIC Code (required)	
Physical Address in Vermont		
City	State	Zip Code
Phone	Fax	
Mailing Address (if different)		
City	State	Zip Code
Group Benefits Administrator	Title	
Phone	Email	
Additional Group Contact	Title	
Phone	Email	
Business Owner(s) (please list business owners, if different than above)		
Are the owners and their spouse the only policy holders on the business health plan? ☐ Yes ☐ No	Does the business or organization offer other insurance in addition to health plans offered through Blue Cross VT? ☐ Yes ☐ No	

Section 2: FINANCIAL ACCOUNTS

Blue Cross® and Blue Shield® of Vermont offers integrated Consumer Driven Health Plan (CDHP) account services. All plans are eligible for HRA accounts. Only specified CDHP plans are eligible for HSA accounts. As an employer you can offer financial accounts to employees to manage their health care expenses and savings at no additional cost.

If you have completed a Plan Design Guide (PDG) for one of the following financial accounts, please check the box below.

☐ Health Reimbursement Arrangement (HRA) ☐ Health Savings Account (HSA)

For more information regarding our integrated financial accounts, visit bluecrossvt.org/MyMoney or contact our MyMoney financial account sales and support team at (866) 999-2605.

Section 3: BROKER INFORMATION (if applicable)

☐ Using a Broker / Broker Agency

If you are using a broker, please list them below. By completing the information below you are listing the broker(s) as an authorized contact(s) for your group with Blue Cross Vermont.

Broker Agency Information

Name of Broker Agency			
Address	City	State	Zip Code

We understand that by listing the below individuals, **Blue Cross Vermont will only speak with the contact(s) from the agency listed below**, and not with other people that may also work at the appointed broker agency named above. This is optional and not required. If you wish to list the broker agency only and not any specific contacts from the Agency as an authorized broker contact(s), please disregard the below section.

Individual Contacts at Broker Agency

Broker Contact Name	Phone	Email
Broker Contact Name	Phone	Email
Broker Contact Name	Phone	Email

This authorization remains in place until written notice is provided to Blue Cross Vermont directing them to remove the contact(s) listed above. We understand that this form, consistent with federal and state law, does not authorize the listed agency or individual broker(s) to obtain individual protected health information of a specific employee, without that employee's consent, other than information needed to manage enrollment and billing.

Section 4: SIGNATURE

SIGN HERE

▶ Group Benefits Administrator Signature (required) _____ Date _____ ◀

Please return your your organzation's enrollment packet to:

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

Email: consumersupport@bcbsvt.com

Fax: (802) 371-3329

Note: Blue Cross Vermont requires the first month's premium payment to process your organization's enrollment application.

Please mail your first month's premium payment to the address above and include proof of payment with your completed enrollment application.

The monthly premium is calculated based on the health plan selection(s) and selected coverage type for all employees included in your submitted enrollment application.

BlueCross BlueShield of Vermont

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

SMALL GROUP CERTIFICATION

For Small Group Qualified Health Plans (QHP)

Please complete this form in its' entirety, otherwise this form will be returned to you.

Section 1: GROUP INFORMATION

Legal Business or Organization Name	Federal Tax ID	
Physical Address in Vermont		
City	State	Zip Code
Phone	Email	
Mailing Address (if different)		
City	State	Zip Code

Section 2: GROUP CENSUS DETAILS

Total Number of Employees on Payroll (including both Full-time & Part-time): _____	Please specify the company's health insurance eligibility policy, stating the minimum number of hours required per week. _____ hours per week

Probationary Period (no more than 90 days): New hires _____ days Adding rehires _____ days

Section 3: ADDITIONAL GROUP INFORMATION

The Consolidated Appropriations Act (CAA) requires health insurance issuers to report certain data elements to the federal government. Among the required data is certain information about prescription drugs and health care spending on an annual basis, including the average monthly premiums paid by employers versus employees. Blue Cross® and Blue Shield® of Vermont is required to gather this information for your organization with your enrollment in our Small Group Qualified Health Plans (QHP).

What will be the **average percentage of monthly premium** paid by your organization for all eligible employee(s) for their health plan?

_____ %

Note: This amount must be an average percentage.

over →

Section 4: GROUP ATTESTATION & SIGNATURE

I. EMPLOYEE CENSUS

As of 2016, the Affordable Care act defines a Small Employer as an entity with up to 100 full-time equivalent employees. To calculate the number of employees, include all employees that work full-time. Full-time, for this purpose, is defined as an employee that works at least 30 hours per week, or 130 hours in a calendar month. Full-time equivalents equal the total part-time employee hours worked in a month divided by 120. Those numbers are added together giving the monthly number. The 12 month totals are then averaged for the final count. Employers with less than 100 full-time equivalents are considered a small group and are allowed to purchase a Small Group Qualified Health Plan.

II. PROOF OF BUSINESS/INSURANCE

When returning your Small Group Certification form you must include the Employer's Quarterly Wage and Contribution Report. Please indicate terminated, seasonal and part-time employees, and the number of hours worked per week by each employee. You may remove Social Security numbers and financial information. If you are not required to file an Employer's Quarterly Wage and Contribution Report (Form C-101) with the Vermont Department of Employment and Training, or with any other state in which you do business, please submit one of the following: IRS Schedule C (Proprietorship); IRS Schedule SE (Self Employed); or IRS Schedule K-1 (Partnership or "S" Corporation).

III. CERTIFICATION

I verify that I have completed the Census information requested on the Employee Census Information form. I certify that I qualify as a Small Employer as described in Section I, and have 100 or fewer full-time and full-time equivalent employees as calculated pursuant to IRS code §4890H(c)(2). I certify that if I am required to file an "Employer's Quarterly Wage and Contribution Report" with the Department of Employment and Training I have attached a copy of the most recent report to this form, or I am a self-employed proprietor and I have attached one of the following: IRS Schedule C (Proprietorship), IRS Schedule SE (Self-Employed) or IRS Schedule K1 (Partnership or "S" Corporation).

I further certify that the information provided above is true and complete. I understand that if the above information is incomplete, untrue, or is not provided in a timely manner, then group health benefits do not have to be offered or continued.

Signature of Officer, Partner or Owner	Date
Signature of Officer, Partner or Owner	Date

Please return completed organization's enrollment paperwork to:

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

E-mail: **consumersupport@bcbsvt.com**

Fax: (802) 371-3329

EMPLOYEE CENSUS INFORMATION

BlueCross BlueShield of Vermont

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

Please complete the employee census below or send us all of the requested information from your most recent Employer's Quarterly Wage and Contribution Report. The employee census must include all current active employees, a list of terminated employees with VIPER/COBRA insurance, and any retirees.

The list of current active employees should include: the owner(s); officer(s); manager(s) and employee(s) of the employer and its partners if the employer is a partnership. All individuals on this list need to match those listed on the Employer's Quarterly Wage Report that you are providing to us. If you are a business owner, please complete the form listing yourself as an employee.

Please use the following letters to complete the "EMPLOYMENT STATUS" column below:

- F: Full-time employee
- P/E: Part-time or Seasonal employee, eligible for benefits
- P/I: Part-time or Seasonal employee, ineligible for benefits
- U: Union employee participating in an employee welfare arrangement established pursuant to a collective bargaining agreement
- C: Continuee under State or Federal Law (VIPER/COBRA)
- R: Retiree, eligible for benefits
- T: Terminated employee

EMPLOYEE NAME: LAST NAME, FIRST INITIAL	HIRE DATE (IF WITHIN PAST 12 MOS.)	NUMBER OF HOURS WORKED PER WEEK	EMPLOYMENT STATUS	STATE WHERE EMPLOYED (IF OTHER THAN VT.)	EMPLOYEE OPTING OUT OF INSURANCE
1.					☐ yes ☐ no
2.					☐ yes ☐ no
3.					☐ yes ☐ no
4.					☐ yes ☐ no
5.					☐ yes ☐ no
6.					☐ yes ☐ no
7.					☐ yes ☐ no
8.					☐ yes ☐ no
9.					☐ yes ☐ no
10.					☐ yes ☐ no
11.					☐ yes ☐ no
12.					☐ yes ☐ no
13.					☐ yes ☐ no
14.					☐ yes ☐ no
15.					☐ yes ☐ no
16.					☐ yes ☐ no
17.					☐ yes ☐ no
18.					☐ yes ☐ no
19.					☐ yes ☐ no
20.					☐ yes ☐ no

2025 COVERAGE ELECTION FORM

For Small Group Qualified Health Plans (QHP)

BlueCross BlueShield of Vermont

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

Please provide all information and print in ink or type.

Requested Effective Date / /

Section 1: GROUP INFORMATION

Group Name:	Group Number:
Group Benefits Administrator Name:	

Section 2: PLAN SELECTION

Select from the options listed below
(Choose up to 13 different plan options)

Vermont Preferred Plans			Vermont Select Plans			Standard Plans						
Vermont Preferred Gold	Vermont Preferred Silver Reflective	Vermont Preferred Bronze	Vermont Select Gold CDHP	Vermont Select Silver CDHP Reflective	Vermont Select Bronze CDHP	Platinum	Gold	Silver Reflective	Bronze	Bronze Integrated	Silver CDHP Reflective	Bronze CDHP
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Aggregate Deductibles						**Stacked Deductibles**					**Aggregate Deductibles**	
The full deductible or out-of-pocket limit must be met collectively by members on the plan before benefits are paid.						Plan pays for an individual once the individual deductible is met (including family plans)					The full deductible or out-of-pocket limit must be met collectively by members on the plan before benefits are paid.	

CDHP - Consumer-Directed Health Plan

Employers are responsible to provide their employees with a Summary of Benefits and Coverage (SBC), which can be found on our website at **bluecrossvt.org/smallbusiness**. For assistance, call us at (800) 255-4550 (TTY/TDD: 711) or email consumersupport@bcbsvt.com. We are available Monday through Friday, 8 a.m. to 4:30 p.m.

☐ I found the SBC on the website and will provide them to my employees

☐ Email the SBC to me at: _____

☐ Mail the SBC to me at the mailing address on file

Section 3: BROKER INFORMATION (if applicable)

☐ Using a Broker Agent(s) / Broker Agency
If you are using a broker, please list them below. By completing the information below you are listing the broker(s) as an authorized contact for your group.

Broker Contact Name(s):	Broker Agency Name:

Section 4: SIGNATURE

SIGN HERE

▶ Group Benefits Administrator Signature (required) _____ Date _____ ◀

Please return this form to:

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

email: consumersupport@bcbsvt.com **fax:** (802) 371-3329

2025 plans and premiums are on next page ⇨

VERMONT PREFERRED PLANS		Employee-only	Employee + Spouse	Employee + Child(ren)	Family
Vermont Preferred Gold	Combined 4-8-12 zero dollar office visits for primary care, mental health, or substance use disorder treatment provider visits with no cost-share before the deductible. Combined medical/prescription drug deductible of $1,250. After the deductible, copayments vary based on services up to the out-of-pocket maximum of $5,150[1]. *Deductible is waived for wellness drugs[2].*	$1,129.14	$2,258.28	$2,179.24	$3,172.88
Vermont Preferred Silver Reflective	Combined 4-8-12 zero dollar office visits for primary care, mental health, or substance use disorder treatment provider visits with no cost-share before the deductible. Combined medical/prescription drug deductible of $3,250. After the deductible, copayments vary based on services up to the out-of-pocket maximum of $8,750[1]. *Deductible is waived for wellness drugs[2].*	$926.86	$1,853.72	$1,788.84	$2,604.48
Vermont Preferred Bronze	Combined 4-8-12 zero dollar office visits for primary care, mental health, or substance use disorder treatment provider visits with no cost-share before the deductible. Combined medical/prescription drug deductible and out-of-pocket maximum of $9,200[1]. *Deductible is waived for wellness drugs[2].*	$816.91	$1,633.82	$1,576.64	$2,295.52
VERMONT SELECT PLANS		**Employee-only**	**Employee + Spouse**	**Employee + Child(ren)**	**Family**
Vermont Select Gold CDHP	Combined medical/prescription drug deductible & out-of-pocket maximum of $2,950. Deductible is waived for wellness drugs[2] and is $5 generic drugs, $50 preferred brand drugs, 60% coinsurance for non-preferred brand drugs up to the prescription drug out-of-pocket maximum of $1,650.	$1,146.17	$2,292.34	$2,212.11	$3,220.74
Vermont Select Silver CDHP Reflective	Combined medical/prescription drug deductible & out-of-pocket maximum of $5,400[1]. Deductible is waived for wellness drugs[2] and is $15 generic drugs, $50 preferred brand drugs, 60% coinsurance for non-preferred brand drugs up to the prescription drug out-of-pocket maximum of $1,650.	$937.14	$1,874.28	$1,808.68	$2,633.36
Vermont Select Bronze CDHP	Combined medical/prescription drug deductible & out-of-pocket maximum of $7,700[1]. Deductible is waived for wellness drugs[2] and is $25 generic drugs, 65% coinsurance for preferred brand drugs, 85% coinsurance for non-preferred brand drugs up to the combined medical/prescription drug out-of-pocket maximum of $7,700.	$810.79	$1,621.58	$1,564.82	$2,278.32

[1]Regardless of all other cost-share, if one person's out-of-pocket cost reaches $9,200 in a year, we begin paying 100% of the allowed amount for that person's covered services and supplies.

[2]For the complete National Performance Formulary (NPF) drug list of our wellness drugs, visit **bluecrossvt.org/formulary-lists**.

Cost-share for each health plan above is based on the employee-only coverage type. Plan benefits may change if the coverage type is different than employee-only coverage.

For specific plan details, review the Summary of Benefits and Coverage (SBC) available on our website at **bluecrossvt.org/smallbusiness**.

Over ⇨

STANDARD PLANS		Employee-only	Employee + Spouse	Employee + Child(ren)	Family
Platinum	$450 medical deductible, then 10% coinsurance up to the medical out-of-pocket maximum of $1,600. Three, zero dollar office visits per member for the combination of primary care, mental health, or substance use disorder treatment provider visits with no cost-share, then $15. $40 specialist office visits. $10 generic drugs, $50 preferred brand drugs, 50% coinsurance for non-preferred brand drugs up to the prescription drug out-of-pocket limit of $1,600.	$1,337.35	$2,674.70	$2,581.09	$3,757.95
Gold	$1,400 medical deductible, then 30% coinsurance up to the medical out-of-pocket maximum of $5,600. Three, zero dollar office visits per member for the combination of primary care, mental health, or substance use disorder treatment provider visits with no cost-share, then $20. $55 specialist office visits. $15 generic drugs, $200 individual or $400 family prescription drug deductible then $60 preferred brand drugs, 50% coinsurance for non-preferred brand drugs up to the prescription drug out-of-pocket limit of $1,600.	$1,138.18	$2,276.36	$2,196.69	$3,198.29
Silver Reflective	$3,500 medical deductible, then 50% coinsurance up to the out-of-pocket maximum of $9,200. Three, zero dollar office visits per member for the combination of primary care, mental health, or substance use disorder treatment provider visits with no cost-share, then $40. $90 specialist office visits. $15 generic drugs, $500 individual or $1,000 family prescription drug deductible then $70 preferred brand drugs, 50% coinsurance for non-preferred brand drugs up to the prescription drug out-of-pocket limit of $1,600.	$937.80	$1,875.60	$1,809.95	$2,635.22
Bronze	$6,450 medical deductible, then 50% coinsurance up to the out-of-pocket maximum of $9,450. $20 generic drugs, $1,100 individual or $2,200 family prescription drug deductible then $85 preferred brand drugs, 60% coinsurance for non-preferred brand drugs up to the prescription drug out-of-pocket limit of $1,600.	$795.67	$1,591.34	$1,535.64	$2,235.83
Bronze Integrated	$9,200 combined medical/prescription drug deductible & out-of-pocket maximum. Three, zero dollar office visits per member for the combination of primary care, mental health, or substance use disorder treatment provider visits with no cost-share, then $40. $50 chiropractic or physical therapy visits. $100 specialist office visits. $25 for generic drugs.	$845.64	$1,691.28	$1,632.09	$2,376.25
Silver CDHP Reflective	$2,100 combined medical/prescription drug deductible, then 10% coinsurance for primary care, mental health, or substance use disorder treatment provider visits. 35% coinsurance for all other medical services up to the out-of-pocket maximum of $7,050[1]. *Deductible is waived for wellness drugs[2].*	$981.98	$1,963.96	$1,895.22	$2,759.36
Bronze CDHP	$5,800 combined medical/prescription drug deductible, then 50% coinsurance for all medical services up to the out-of-pocket maximum of $7,200[1]. *Deductible is waived for wellness drugs[2].*	$844.49	$1,688.98	$1,629.87	$2,373.02

[1]Regardless of all other cost-share, if one person's out-of-pocket cost reaches $9,200 in a year, we begin paying 100% of the allowed amount for that person's covered services and supplies.

[2]For the complete National Performance Formulary (NPF) drug list of our wellness drugs, visit **bluecrossvt.org/formulary-lists**.

Cost-share of each health plan above is based on the employee-only coverage type. Plan benefits may change if the coverage type is different than employee-only coverage.

For specific plan details, review the Summary of Benefits and Coverage (SBC) available on our website at **bluecrossvt.org/smallbusiness**.

SMALL GROUP EMPLOYEE

Enrollment & Change Form for Small Group Qualified Health Plans

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 2 for details.

(888) 320-9798 (TTY/TDD: 711), option 3
bluecrossvt.org/smallbusiness

Please provide all information printed in ink or type.

Requested Effective Date ___/___/___

Section 1: EMPLOYEE INFORMATION

Group Name:

Group Number/Division:

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

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

First Name:	Last 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:	Gender: ☐ Male ☐ Female	
Primary Care Provider (PCP) Name, or NPI number[3] Are you a current patient? ☐ Yes ☐ No	Marital Status: ☐ Single ☐ Divorced ☐ Domestic Partner[2] ☐ Married/party to a civil union	Employment Status: ☐ Active ☐ Retired ☐ Continuation	

Health Coverage Type: ☐ Employee only ☐ Employee & Spouse (including party to a civil union/domestic partner) ☐ Employee & Child(ren) ☐ 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 Blue Cross VT plan, Member ID # _____

Section 3: CHANGE/CANCELLATION

CHANGE: (Including SEP's)

Event date ___/___/____

☐ Pregnancy
☐ Birth
☐ Adoption Placement Date ___/___/____
☐ Marriage/Civil Union
☐ Divorce
☐ Address Change
☐ Name Change

☐ PCP Change
☐ Court Ordered Change[2]
☐ Loss of Coverage[2]
☐ Domestic Partner[4]

Domestic Partners may only be enrolled with a qualifying event outside of Open Enrollment. By submitting this form, the employer acknowledges they have a copy of the completed and notarized Statement of Domestic Partnership in their records.

CANCEL:

Date of Cancellation ___/___/____

☐ Voluntary Cancel (Subscriber Signature Required)

_____

Proof of other insurance is required to complete this request, if submitted outside of group's Open Enrollment period. Please include documentation when returning the form.

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

Section 5: OTHER INSURANCE INFORMATION

If you obtain a health plan with Blue Cross VT, 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: 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:	**Fax:**	**Mail:**
asinbox@bcbsvt.com	(802) 371-3329	Blue Cross and Blue Shield of Vermont P.O. Box 186 Montpelier, VT 05601-0186

If you are adding an adult dependent, 26 or older, contact customer service at (800) 247-2583 (TTY/TDD: 711) 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**

BlueCross BlueShield of Vermont

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

(800) 255-4550 (TTY/TDD: 711)

bluecrossvt.org/smallbusiness

2025 PLAN SELECTION FORM

Employer and Employee use only

Please provide all information printed in ink or type.

Requested Effective Date

/ /

Submit form to:

This form must be returned to:	Submit by:
Group Benefits Administrator	Date

Section 1: EMPLOYER/EMPLOYEE INFORMATION

Group name:	Member ID #:
First name:	Last name:

Section 2: PLAN SELECTION

Vermont Preferred Plans			Vermont Select Plans			Standard Plans						
Vermont Preferred Gold	Vermont Preferred Silver Reflective	Vermont Preferred Bronze	Vermont Select Gold CDHP	Vermont Select Silver CDHP Reflective	Vermont Select Bronze CDHP	Platinum	Gold	Silver Reflective	Bronze	Bronze Integrated	Silver CDHP Reflective	Bronze CDHP

Blue Cross Vermont Health Plans Offered by Employer

Employer Selection (may choose up to 13 plans)

☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐☐

Employee Selection (choose plan below)

☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐☐

Aggregate Deductibles
The full deductible or out-of-pocket limit must be met collectively by members on the plan before benefits are paid

Stacked Deductibles
Plan pays for an individual once the individual deductible is met (including family plans)

Aggregate Deductibles
The full deductible or out-of-pocket limit must be met collectively by members on the plan before benefits are paid

The following amount will be paid toward your premiums: ☐ Weekly ☐ Bi-weekly ☐ Monthly

$_____ Employee-only

$_____ Employee + Spouse

$_____ Employee + Child(ren)

$_____ Family

Section 3: ACCEPT OR DECLINE ENROLLMENT

☐ I select the plan above as my 2025 health plan selection.

I understand that I can find the plans Summary of Benefits and Coverage (SBC) at **bluecrossvt.org/smallbusiness** or my employer has provided me a copy.

☐ I decline

If you are declining enrollment for yourself or your dependents (including your spouse) because of another health plan or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 60 days after you or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

If you or your dependent lose eligibility for a public benefit program, such as Dr. Dynasaur, you or your dependent may be eligible for coverage under this group health plan. In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 60 days after the loss of eligibility, marriage, birth, adoption, or placement for adoption.

Section 4: EMPLOYEE SIGNATURE

SIGN HERE

▶ Employee Signature _____ Date _____ ◀

Note: This form is not a substitute as an application for new enrollment or membership changes. Please complete the small group coverage employee enrollment and change form.

DISCLAIMERS

General Exclusions

While your health plan covers a broad array of necessary services and supplies, it doesn't cover every possible medical expense. If you would like to review the list of general exclusions before enrolling, visit **bluecrossvt.org/contracts**, click on the plan in which you are enrolling and read the chapter entitled "General Exclusions." Once you enroll, you will receive an Outline of Coverage and a link to your Certificate of Coverage. Please read both carefully as they govern your specific benefits.

How We Protect Your Privacy

The law requires us to maintain the privacy of your health information by using or disclosing it only with your authorization or as otherwise allowed by law. You may find information about our privacy practices at **bluecrossvt.org/privacypolicies**.

NOTICE: Discrimination is Against the Law

Blue Cross® and Blue Shield® of Vermont (Blue Cross VT) and its affiliate The Vermont Health Plan (TVHP) comply with applicable federal and state civil rights laws and do not discriminate, exclude people or treat them differently on the basis of race, color, national origin, age, disability, gender identity or sex, ethnicity, sexual orientation, or HIV-status.

Blue Cross VT provides free aids and services to people with disabilities to communicate effectively with us. We provide, for example, qualified sign language interpreters and written information in other formats (e.g., large print, audio or accessible electronic format).

Blue Cross VT provides free language services to people whose primary language is not English. We provide, for example, qualified interpreters and information written in other languages.

If you need these services, contact Whitney Standefer-Smith, **civilrightscoordinator@bcbsvt.com**.

If you believe that Blue Cross VT has failed to provide these services or discriminated in another way based on race, color, national origin, age, disability, gender identity or sex, ethnicity, sexual orientation, or HIV-Status, you can file a grievance with: Whitney Standefer-Smith, Civil Rights Coordinator, P.O. Box 186, Montpelier, VT 05601-0186, call (800) 247-2583 (TTY/TDD: 711), fax (802) 229-0511, or email **civilrightscoordinator@bcbsvt.com**. You can file a grievance in person, by mail, via fax, or by email. If you need help filing a grievance, Whitney Standefer-Smith, the Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically or through the Office for Civil Rights Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW Room 509F
HHH Building Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at
https://www.hhs.gov/ocr/complaints/index.html

For free language-assistance service, call (800) 247-2583 (TTY/TDD: 711).

ARABIC	(800) للحصول على خدمات المساعدة اللغوية المجانية ، اتصل 2583 247 (TTY/TDD: 711). lilhusul ealaa khadmat almusaeadat allughawiat almajaaniat, atasal (800) 247-2583 (TTY/TDD: 711).
CHINESE	如需免费语言协助服务，请致电，(800) 247-2583 (TTY/TDD: 711). Rú xū miǎnfèi yǔyán xiézhù fúwù, qǐng zhìdiàn (800) 247-2583 TTY/TDD: 711).
CUSHITE (OROMO)	Tajaajila gargaarsa afaanii bilisaa argachuuf, (800) 247-2583 (TTY/TDD: 711) bilbili.
FRENCH	Pour des services d'assistance linguistique gratuits, appelez le (800) 247-2583 (TTY/TDD: 711).
GERMAN	Für kostenlose Sprachunterstützungsdienste rufen Sie (800) 247-2583 (TTY/TDD: 711) an.
ITALIAN	Per i servizi di assistenza linguistica gratuiti, chiamare il numero (800) 247-2583 (TTY/TDD: 711).
JAPANESE	無料の言語支援サービスについては, (800) 247-2583 (TTY/TDD: 711). Muryō no gengo shien sābisu ni tsuite wa, (800) 247-2583 (TTY/TDD: 711) made o denwa kudasai.
NEPALI	निःशुल्क भाषा-सहायता सेवाहरूको लागि, कल गर्नुहोस् , (800) 247-2583 (TTY/TDD: 711). Niḥśulka bhāṣā-sahāyatā sēvāharūkō lāgi, kala garnuhōs (800) 247-2583 (TTY/TDD: 711).
PORTUGUESE	Para serviços gratuitos de assistência linguística, ligue para (800) 247-2583 (TTY/TDD: 711).
RUSSIAN	Чтобы получить бесплатную языковую помощь, позвоните по телефону (800) 247-2583 (TTY/TDD: 711).
SERBO-CROATIAN (SERBIAN)	За бесплатне услуге језичке помоћи позовите (800) 247-2583 (TTY/TDD: 711). Za besplatne usluge jezičke pomoći pozovite (800) 247-2583 (TTY/TDD: 711).
SPANISH	Para servicios gratuitos de asistencia lingüística, llame al (800) 247-2583 (TTY/TDD: 711).
TAGALOG	PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa (800) 247-2583 (TTY/TDD: 711).
THAI	สำหรับบริการช่วยเหลือด้านภาษาฟรี โทร,(800) 247-2583 (TTY/TDD: 711). S̄ảh̄rạb brikār ch̀wyh̄elp̄x d̂ān p̣hās'ā frī thor (800) 247-2583 (TTY/TDD: 711).
UKRAINIAN	Щоб отримати безкоштовні мовні послуги, телефонуйте (800) 247-2583 (TTY/TDD: 711). Shchob otrymaty bezkoshtovni movni posluhy, telefonuyte (800) 247-2583 (TTY/TDD: 711)
VIETNAMESE	Đối với các dịch vụ hỗ trợ ngôn ngữ miễn phí, hãy gọi (800) 247-2583 (TTY/TDD: 711).