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**

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).