NEW SMALL GROUP APPLICATION CHECKLIST

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

For Small Group Qualified Health Plans (QHP)

☑ **Please return the following documentation to Blue Cross and Blue Shield of Vermont to complete your new small group enrollment.**

List of Required Documentation:

- ☐ Completed **Small Group Enrollment Agreement** form
- ☐ Completed **Small Group Certification** form
- ☐ Completed **Employee Census Information** form
- ☐ Completed **2027 Coverage Election** form
- ☐ Completed **Small Group Employee Enrollment and Change Form for Small Group Qualified Health Plans** for each employee enrolling in the group plan.

☐ **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 ■ 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

Important Note:

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

Next Steps:

- ☐ Enrollees can complete a **Continuity of Care** form if they are being treated for a life threatening or 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 provide 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: Blue Cross and Blue Shield of Vermont
P.O. Box 186
Montpelier, VT 05601-0186

SMALL GROUP ENROLLMENT AGREEMENT

For Small Group Qualified Health Plans (QHP)

BlueCross BlueShield of Vermont

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

Please complete the entire form. Incomplete forms will be returned.

**Required Information*

SECTION 1: GROUP DETAILS

Legal Business or Organization Name*	**Requested Effective Date***	
DBA name (if applicable)	Federal Tax ID*	
Nature of Business or Organization*	SIC Code*	
Organization Type* ☐ Limited Liability Company ☐ C Corp ☐ S Corp ☐ Partnership ☐ Nonprofit ☐ Government ☐ Church Group ☐ Trust ☐ Other _____		
Group Physical Address in Vermont*		
City*	State*	ZIP Code*
Group Phone Number*	Fax	
Mailing Address (if different)		
City	State	ZIP Code
Group Benefits Administrator*	Title*	
Phone Number*	Email*	
Additional Group Benefits Adminstrator	Title	
Phone Number	Email	
Business Owner(s) (if different than above)		
Will the group health plan cover anyone other than the business owner and their spouse?* ☐ Yes ☐ No	Does the business or organization provide any additional health insurance coverage beyond the plans offered through Blue Cross VT?* ☐ Yes ☐ No	

OVER →

SECTION 2: HEALTH SPENDING ACCOUNTS

Blue Cross VT provide employers with the option to pair health spending accounts with our group health plans at no additional cost per member per month* (PMPM). These accounts help employees manage their health care expenses and savings, and all group qualified health plans are eligible for HRA accounts. Only specified Consumer-Directed Health Plans (CDHP) are eligible for HSA accounts.

If you've completed a New Business Notification form with HealthEquity, our health spending account vendor, please indicate which account type(s) below. To complete the form, visit **sales.healthequity.com/bcbsvt**.

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

To explore pairing health spending accounts with your group health plan, visit **bluecrossvt.org/HSA-HRA** or contact HealthEquity employer services at (866) 382-3510 or email **employerservices@bcbsvt.com**. Brokers can contact HealthEquity broker services at (800) 819-5852 or email **brokerservices@healthequity.com**.

*An initial set-up and renewal fee of $250 applies for HRA accounts.

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 and Blue Shield of Vermont.

BROKER AGENCY INFORMATION

Name of Broker Agency			
Address	City	State	ZIP Code

We understand that by listing the below individuals, **Blue Cross and Blue Shield of 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 and Blue Shield of 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* _____ Date* _____ ◀

OVER →

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 VT requires the first month's premium payment to process your business or organization's group enrollment forms.

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

The monthly premium is calculated based on the selected health plan(s) and membership types for all employees included with your submitted group enrollment forms.

SMALL GROUP CERTIFICATION

For Small Group Qualified Health Plans (QHP)

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

Please complete the entire form. Incomplete forms will be returned.

**Required Information*

SECTION 1: GROUP DETAILS

Legal Business or Organization Name*	Federal Tax ID*	
Group Physical Address in Vermont*		
City*	State*	ZIP Code*
Group Phone Number*	Group 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 your group's health insurance eligibility policy, stating the minimum number of hours required per week.*
_____ hours per week

Probationary Period (cannot exceed 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 business or organization with your enrollment in our small group qualified health plans.

What will be the **average percentage of monthly premium** paid by your business or 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

Since 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 group enrollment forms 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

2027 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 health plans listed below
(Choose up to 13 different plans)

Vermont Preferred Plans			Vermont Select Plans			Standard Plans						
Vermont Preferred Gold	Vermont Preferred Silver	Vermont Preferred Bronze	Vermont Select Gold CDHP*	Vermont Select Silver CDHP*	Vermont Select Bronze CDHP*	Platinum	Gold	Silver	Bronze	Bronze Integrated	Silver CDHP*	Bronze CDHP*
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Aggregate Deductibles	Stacked Deductibles	Aggregate Deductibles
Once all members on the health plan meet their collective deductible, the health plan pays accordingly.	Once a member meets their deductible, the health plan pays accordingly, even for a two-person or family plan.	Once all members on the health plan meet their collective deductible, the health plan pays accordingly.

*CDHP: Consumer-Directed Health Plan

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

☐ 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

2027 plans and premiums

OVER →

VERMONT PREFERRED PLANS		Employee-only	Two-person	Employee + Child(ren)	Family
Vermont Preferred Gold	$0 office visits for the first combined 4, 8, or 12 primary care, mental health, or substance use disorder treatment providers before the deductible. Combined medical & prescription drug deductible of $1,550. After the deductible, copayments vary based on services up to the $5,650 out-of-pocket maximum.Deductible is waived for wellness medications, with wellness generic drugs covered at $5, wellness preferred brand drugs at $50, and wellness non-preferred brand drugs at 50% coinsurance for each 30-day supply up to the $1,750 prescription drug out-of-pocket maximum. All other medications are subject to the deductible.[2]	$1,186.83	$2,373.66	$2,290.58	$3,334.99
Vermont Preferred Silver	$0 office visits for the first combined 4, 8, or 12 primary care, mental health, or substance use disorder treatment providers before the deductible. Combined medical & prescription drug deductible of $3,750. After the deductible, copayments vary based on services up to the $9,850 out-of-pocket maximum.[1] Deductible is waived for wellness medications, with wellness generic drugs covered at $5, wellness preferred brand drugs at $50, and wellness non-preferred brand drugs at 50% coinsurance for each 30-day supply up to the $1,750 prescription drug out-of-pocket maximum. All other medications are subject to the deductible.[2]	$983.33	$1,966.66	$1,897.83	$2,763.16
Vermont Preferred Bronze	$0 office visits for the first combined 4, 8, or 12 primary care, mental health, or substance use disorder treatment providers before the deductible. Combined medical & prescription drug deductible and out-of-pocket maximum of $10,900.[1] Deductible is waived for wellness medications, with wellness generic drugs covered at $15, wellness preferred brand drugs at $50, and wellness non-preferred brand drugs at 50% coinsurance for each 30-day supply up to the $10,900 prescription drug out-of-pocket maximum. All other medications are subject to the deductible.[2]	$838.02	$1,676.04	$1,617.38	$2,354.84
VERMONT SELECT PLANS		**Employee-only**	**Two-person**	**Employee + Child(ren)**	**Family**
Vermont Select Gold CDHP	Combined medical & prescription drug deductible and out-of-pocket maximum of $3,400. Deductible is waived for wellness medications, with wellness generic drugs covered at $5, wellness preferred brand drugs at $50, and wellness non-preferred brand drugs at 50% coinsurance for each 30-day supply up to the $1,750 prescription drug out-of-pocket maximum. All other medications are subject to the deductible.[2]	$1,190.12	$2,380.24	$2,296.93	$3,344.24
Vermont Select Silver CDHP	Combined medical & prescription drug deductible and out-of-pocket maximum of $6,300.[1] Deductible is waived for wellness medications, with wellness generic drugs covered at $15, wellness preferred brand drugs at $50, and wellness non-preferred brand drugs at 50% coinsurance for each 30-day supply up to the $1,750 prescription drug out-of-pocket maximum. All other medications are subject to the deductible.[2]	$976.07	$1,952.14	$1,883.82	$2,742.76
Vermont Select Bronze CDHP	Combined medical & prescription drug deductible & out-of-pocket maximum of $8,700.[1] Deductible is waived for wellness medications, with wellness generic drugs covered at $25, wellness preferred brand drugs at 40% coinsurance, and wellness non-preferred brand drugs at 50% coinsurance for each 30-day supply up to the $8,700 prescription drug out-of-pocket maximum. All other medications are subject to the deductible.[2]	$843.09	$1,686.18	$1,627.16	$2,369.08

[1]Regardless of all other cost-share, if one person's out-of-pocket cost reaches $12,000 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 and our NPF wellness medication list, visit **bluecrossvt.org/formulary-lists**.

Cost-share for each health plan above is based on the employee-only membership type. Plan benefits may change for two-person, employee + child(ren), or family membership types. For specific plan details, review each plan's Summary of Benefits and Coverage (SBC) at **bluecrossvt.org/smallbusiness**.

OVER →

STANDARD PLANS		Employee-only	Two-person	Employee + Child(ren)	Family
Platinum	$700 medical deductible with 10% coinsurance up to the $2,650 medical out-of-pocket maximum. Three $0 primary care, mental health, or substance use disorder treatment provider office visits combined per member before $15 applies and $30 specialist visits. Generic drugs are covered at $10, $50 for preferred brand, and 50% coinsurance for non-preferred brand for each 30-day supply up to the $1,750 prescription drug out-of-pocket maximum.[2]	$1,445.91	$2,891.82	$2,790.61	$4,063.01
Gold	$1,700 medical deductible with 30% coinsurance up to the $6,000 medical out-of-pocket maximum. Three $0 primary care, mental health, or substance use disorder treatment provider office visits combined per member before $20 applies and $55 specialist visits. Generic drugs are covered at $15. For preferred brand and non-preferred brand, $400 individual or $800 family prescription drug deductible applies before covered at $60 for preferred and 50% coinsurance for non-preferred for each 30-day supply up to the $1,750 prescription drug out-of-pocket maximum.[2]	$1,201.61	$2,403.22	$2,319.11	$3,376.52
Silver	$3,500 medical deductible with 50% coinsurance up to the $11,300 out-of-pocket maximum. Three $0 primary care, mental health, or substance use disorder treatment provider office visits combined per member before $40 applies and $90 specialist visits. Generic drugs are covered at $15. For preferred brand and non-preferred brand, $550 individual or $1,100 family prescription drug deductible applies before covered at $70 for preferred and 50% coinsurance for non-preferred for each 30-day supply up to the $1,750 prescription drug out-of-pocket maximum.[2]	$995.23	$1,990.46	$1,920.79	$2,796.60
Bronze	$6,450 medical deductible with 50% coinsurance up to the $11,100 out-of-pocket maximum. Generic drugs are covered at $15. For preferred brand and non-preferred brand, $1,100 individual or $2,200 family prescription drug deductible applies before covered at $85 for preferred, 60% coinsurance for non-preferred for each 30-day supply up to the $1,750 prescription drug out-of-pocket maximum.[2]	$835.33	$1,670.66	$1,612.19	$2,347.28
Bronze Integrated	$12,000 combined medical & prescription drug deductible and out-of-pocket maximum. Three $0 primary care, mental health, or substance use disorder treatment provider office visits combined per member before $40 applies, $50 chiropractic or physical therapy visits, and $100 specialist visits. Generic drugs are covered at $25 for each 30-day supply. All other medications are subject to the deductible.[2]	$857.63	$1,715.26	$1,655.23	$2,409.94
Silver CDHP	$2,500 combined medical & prescription drug deductible with 10% coinsurance for primary care, mental health, or substance use disorder treatment provider office visits and 35% coinsurance for all other medical services up to the $7,500 out-of-pocket maximum.[1] Deductible is waived for our wellness medications with wellness generics covered at $10, wellness preferred brand at $40, and 50% coinsurance for wellness non-preferred brand drugs for each 30-day supply up to the $1,750 prescription drug out-of-pocket maximum. All other medications are subject to the deductible.[2]	$1,030.22	$2,060.44	$1,988.32	$2,894.92
Bronze CDHP	$6,300 combined medical & prescription drug deductible with 50% coinsurance for all medical services up to the $7,800 out-of-pocket maximum.[1] Deductible is waived for our wellness medications with wellness generics covered at $12, 40% coinsurance for preferred brand, and 60% coinsurance for wellness non-preferred brand drugs for each 30-day supply up to the $1,750 prescription drug out-of-pocket maximum. All other medications are subject to the deductible.[2]	$891.93	$1,783.86	$1,721.42	$2,506.32

[1]Regardless of all other cost-share, if one person's out-of-pocket cost reaches $12,000 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 and to view our available wellness drugs, visit **bluecrossvt.org/formulary-lists**.

Cost-share for each health plan above is based on the employee-only membership type. Plan benefits may change for two-person, employee + child(ren), or family membership types. For specific plan details, review each plan's Summary of Benefits and Coverage (SBC) 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 3 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: SUBSCRIBER INFORMATION

Group Name:				
Group Number/Division:				
First Name:	Middle Initial:	Last Name:	Social Security Number (SSN)[1]:	Date of Birth:
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 (COBRA)	

SECTION 2: ENROLLMENT SELECTION

PLAN SELECTION:

Vermont Preferred Plans:

☐ Vermont Preferred Gold ☐ Vermont Preferred Silver ☐ Vermont Preferred Bronze

Vermont Select Plans:

☐ Vermont Select Gold CDHP ☐ Vermont Select Silver CDHP ☐ Vermont Select Bronze CDHP

Standard Plans:

☐ Platinum ☐ Gold ☐ Silver ☐ Bronze ☐ Bronze Integrated ☐ Silver CDHP ☐ Bronze CDHP

MEMBERSHIP TYPE:

☐ Employee-only ☐ Two-person ☐ Employee + Child(ren) ☐ Family

SECTION 3: ENROLLMENT REASON

☐ New group ☐ Open Enrollment ☐ New hire/re-hire ☐ Continuation of coverage (COBRA/VIPER)

☐ Spouse turning age 65 ☐ Special Enrollment Period (SEP) ***please specify the qualifying event in Section 4***

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

Please see Section 7 on page 3 for Subscriber Signature

SECTION 4: CHANGE/TERMINATION

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

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.

TERMINATION:

Date of Cancel ___/___/_____

☐ Voluntary Cancel (Subscriber Signature Required)

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

☐ Left Employment

(Group Benefits Administrator Signature)

Other (explain) _____

SECTION 5: FAMILY MEMBER INFORMATION

Please include all family member(s) information to be added or removed for this policy.

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

☐ Add ☐ Remove Spouse/party to a civil union/domestic partner First Name: Last Name:	SSN[1] DOB	Gender ☐ Male ☐ Female	Primary Care Provider (PCP) Information[3] 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 6: OTHER INSURANCE INFORMATION

If you obtain a health plan with Blue Cross VT, will you or any of your family member(s) be covered with an additional health insurance plan (including Medicare or Medicaid) or dental insurance plan?

☐ Yes (please complete the applicable section below) ☐ No

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

SECTION 7: 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

▶ Subscriber 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

2027 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	Vermont Preferred Bronze	Vermont Select Gold CDHP	Vermont Select Silver CDHP	Vermont Select Bronze CDHP	Platinum	Gold	Silver	Bronze	Bronze Integrated	Silver CDHP	Bronze CDHP

Blue Cross VT Health Plans Offered by Employer

Employer Selection (may choose up to 13 plans)

☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

Employee Selection (choose plan below)

☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

Aggregate Deductibles
Once all members on the health plan meet their collective deductible, the health plan pays accordingly.

Stacked Deductibles
Once a member meets their deductible, the health plan pays accordingly, even for a two-person or family plan.

Aggregate Deductibles
Once all members on the health plan meet their collective deductible, the health plan pays accordingly.

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

$_____ Employee-only $_____ Two-person $_____ Employee + Child(ren) $_____ Family

SECTION 3: ACCEPT OR DECLINE ENROLLMENT

☐ I select the plan above as my 2027 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 Employee Enrollment & 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 who speak or sign languages other than English. We provide, for example, qualified interpreters and information written in other languages.

If you need these services, contact the Civil Rights Coordinator at **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: 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, 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 العربية	للحصول على خدمة المساعدة اللغوية المجانية، اتصل على الرقم (800) 247-2583 (TTY/TDD: 711). lilhusul ealaa khadmat almusaeadat allughawiat almajaaniat, atasal (800) 247-2583 (TTY/TDD: 711).
BOSNIAN BOSANSKI	Za besplatnu uslugu jezičke pomoći nazovite (800) 247-2583 (TTY/TDD: 711).
BURMESE မြန်မာဘာသာ	အခမဲ့ ဘာသာစကားအကူအညီ ဝန်ဆောင်မှုအတွက် (800) 247-2583 (TTY/TDD: 711) သို့ ဖုန်းခေါ်ပါ။
DARI دری	د وړیا ژبنی مرستې خدماتو لپاره، له (800) 247-2583 (TTY/TDD: 711) شمیرې سره اړیکه ونیسئ
FRENCH FRANÇAIS	Pour des services d'assistance linguistique gratuits, appelez le (800) 247-2583 (TTY/ TDD: 711).
KIRUNDI IKIRUNDI	Niba ukeneye ubwunganizi mu ndimi ku buntu, hamagara kuri (800) 247-2583 (TTY/TDD: 711).
NEPALI नेपाली	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).
PASHTO پښتو	برای خدمات رایگان کمک زبانی، با شماره (800) 247-2583 (TTY/TDD: 711) تماس بگیرید
SIMPLIFIED CHINESE 简体中文	如需免费语言协助服务，请拨打 (800) 247-2583 (TTY/TDD: 711)。
SOMALI SOOMAALI	Si aad u hesho adeeg caawimo luuqadeed ah oo bilaash ah, wac (800) 247-2583 (TTY/TDD: 711).
SPANISH ESPAÑOL	Para servicios gratuitos de asistencia lingüística, llame al (800) 247-2583 (TTY/TDD: 711).
SWAHILI KISWAHILI	Kwa huduma ya usaidizi wa lugha bila malipo, piga simu kwa (800) 247-2583 (TTY/TDD: 711).
THAI ไทย	สำหรับบริการช่วยเหลือด้านภาษาฟรี โทร, (800) 247-2583 (TTY/TDD: 711). S̄å ĥrạb brikār ch̀wyh̄elūx dān phās̄'ā frī thor (800) 247-2583 (TTY/T̄DD: 711).
UKRAINIAN УКРАЇНСЬКА МОВА	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 TIẾNG VIỆT	Đối với các dịch vụ hỗ trợ ngôn ngữ miễn phí, hãy gọi (800) 247-2583 (TTY/TDD: 711).