

SMALL GROUP EMPLOYEE

Enrollment & Change Form for Small Group Qualified Health Plans



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 number³

Marital Status:

☐ Single ☐ Divorced

☐ Domestic Partner²

☐ Married/party to
a civil union

Employment Status:

☐ Active ☐ Retired

☐ Continuation (COBRA)

Are you a current patient? ☐ Yes ☐ No

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 Change²

☐ Loss of Coverage²

☐ 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

Primary Care Provider
(PCP) Information³

☐ Add ☐ Remove

Spouse/party to a civil union/domestic partner

First Name:

Last Name:

SSN¹

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 & older²

First Name:

Last Name:

SSN¹

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 & older²

First Name:

Last Name:

SSN¹

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 & older²

First Name:

Last Name:

SSN¹

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			DENTAL		
Insurance company (name and address)			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: asinbox@bcbsvt.com	Fax: (802) 371-3329	Mail: Blue Cross and Blue Shield of Vermont P.O. Box 186 Montpelier, VT 05601-0186
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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 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 وړيا ژبني مرستې خدماتو لپاره، له شميرې سره اړيکه ونيسئ (800) 247-2583 (TTY/TDD: 711)

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). Nihşulka 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). Sǎhrəb brikār ch̥wyʰelūx dân phās̃'ā frī thor (800) 247-2583 (TTY/TDD: 711).

UKRAINIAN
УКРАЇНСЬКА
МОБА

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).