BROKER AUTHORIZATION FORM

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

Section 1: GROUP INFORMATION

Group Number:	Group Name:	**Requested Effective Date:** / /

Section 2: BROKER AGENCY INFORMATION

Name of Broker Agency:

Address:	City:	State:	ZIP code:

Section 3: AUTHORIZATION LEVEL (select one)

◯ **Broker of record:**

- Has access to our membership and billing records and is able to speak with Blue Cross and Blue Shield of Vermont (BCBSVT) on our behalf.

◯ **Broker of record and authorized contact:**

- Has access to our membership and billing records and is able to speak with BCBSVT on our behalf.
- Is authorized to the same level as our group benefits manager and is able to submit enrollment change requests on our behalf.

Section 4: INDIVIDUAL CONTACTS AT BROKER AGENCY (optional)

We understand that by listing the below individuals, **BCBSVT will only speak with the contacts listed from the agency**, and not with other people that may also work at the agency. Specific authorized individuals **(no more than three)**:

Last name:	First name:	Email address:
Last name:	First name:	Email address:
Last name:	First name:	Email address:

Section 5: SIGNATURE

This authorization remains in place until we provide written notice to Blue Cross and Blue Shield of Vermont (BCBSVT) 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 company or individual(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.

SIGN HERE

▶ Signature _____ Date _____ ◀

Authorized Group Representative

Submit one of three ways:

Email:	**Fax:**	**Mail:**
asinbox@bcbsvt.com	(802) 371-3329	Blue Cross Blue Shield of Vermont P.O. Box 186 Montpelier, VT 05601-0186