An Independent Licensee of the Blue Cross and Blue Shield Association

GROUP ENROLLMENT/CHANGE FORM

PLEASE TYPE OR PRINT (IN PEN)

Group Benefit Administrators (GBA) enrolling new employees may submit this form online at www.bcbsvt.com/groupenrollment. GBA or employee may complete all other transactions using our interactive PDF at www.bcbsvt.com/groupenrollmentform. Type information in, print, sign and submit one of three ways, email: asinbox@bcbsvt.com, fax: 802-371-3329, or mail: BCBSVT P.O. Box 186 Montpelier, VT 05601.

REQUESTED EFFECTIVE DATE / /

SECTION 1 - EMPLOYER/EMPLOYEE INFORMATION

APPLYING FOR ☐ VHP ☐ TVHP BLUECARE ☐ VFP ☐ J PLAN ☐ COMP ☐ COMP HSA BLUE ☐ TVHP HSA BLUECARE ☐ ____________

EMPLOYER NAME

ACCOUNT NO. (eight to nine characters i.e. 12345000 or T12345650)

SOCIAL SECURITY NO. | LAST NAME | FIRST NAME

MAILING ADDRESS | CITY | STATE | ZIP CODE

HOME PHONE NO.

MARITAL STATUS ☐ SINGLE ☐ MARRIED/PARTY TO A CIVIL UNION ☐ DOMESTIC PARTNER** ☐ DIVORCED ☐ WIDOWED

EMPLOYMENT STATUS ☐ ACTIVE ☐ RETIRED ☐ CONTINUATION

DATE HIRED/REHIRED/or BECAME FULL TIME

HEALTH COVERAGE TYPE (*Includes Party to a Civil Union or Domestic Partner) ☐ EMPLOYEE ONLY ☐ EMPLOYEE/SPOUSE* ☐ EMPLOYEE/CHILD ☐ EMPLOYEE/CHILDREN ☐ FAMILY

SECTION 2 - NEW ENROLLMENT (Check one, then go to SECTION 5)

☐ NEW HIRE ☐ RE-HIRE ☐ CONVERT TO CARVEOUT* (Attach copy of Medicare Card) ☐ SPOUSE TURNING AGE 65 ☐ OPEN ENROLLMENT ☐ CONTINUATION OF COVERAGE (COBRA/VIPER)

☐ REFUSAL ☐ NEW GROUP ☐ TRANSFERRED FROM ANOTHER BCBSVT PLAN Transferring From Certificate No. ____________________

SECTION 3 - CHANGE (Check all that apply)

DATE OF EVENT ____________ REASON FOR CHANGE EVENT ☐ BIRTH ☐ MARRIAGE/CIVIL UNION ☐ DIVORCE ☐ DEATH

☐ ADOPTION ☐ LOSS OF COVERAGE** ☐ ENTER/DISCHARGE FROM MILITARY ☐ COURT ORDERED CHANGE** ☐ STUDENT (Please fill out SECTION 6 also)

☐ ADD/REMOVE SPOUSE/PARTY TO CIVIL UNION OR DEPENDENT (List in SECTION 5) ☐ ADDRESS CHANGE ☐ NAME CHANGE ☐ PCP CHANGE ☐ OTHER (explain)____________

SECTION 4 - POLICY CANCELLATION - Signature Required

☐ VOLUNTARY CANCEL (Subscriber Signature)

☐ LEFT EMPLOYMENT (Group Benefits Manager Signature)

☐ CANCEL CONTINUATION COVERAGE (Subscriber or Group Benefits Manager)

☐ OTHER, explain____________ (Subscriber Signature)

SIGN HERE BELOW:

X ________________________________

SECTION 5 - LIST ALL MEMBERS BELOW TO BE ADDED OR REMOVED

IMPORTANT NOTE: If member is 45 or older SSN is required (Federal mandate requires the collection of SSN) If member is 19 or older Section 6 is also required to be filled out.

MEMBER INFORMATION				PRIMARY CARE PHYSICIAN (PCP) INFORMATION (IF MANAGED CARE)
☐ ADD ☐ REMOVE - Subscriber Last Name	First Name	Social Security No.****	☐ Male ☐ Female DATE OF BIRTH / /	PCP Name / PCP or NPI No.*** Are you a current patient? ☐ Yes ☐ No
☐ ADD ☐ REMOVE - Spouse/Party to a Civil Union Last Name	First Name	Social Security No.****	☐ Male ☐ Female DATE OF BIRTH / /	PCP Name / PCP or NPI No.*** Are you a current patient? ☐ Yes ☐ No
☐ ADD ☐ REMOVE - Dependent Child Last Name	First Name	Social Security No.****	☐ Male ☐ Female DATE OF BIRTH / /	PCP Name / PCP or NPI No.*** Are you a current patient? ☐ Yes ☐ No
☐ ADD ☐ REMOVE - Dependent Child Last Name	First Name	Social Security No.****	☐ Male ☐ Female DATE OF BIRTH / /	PCP Name / PCP or NPI No.*** Are you a current patient? ☐ Yes ☐ No
☐ ADD ☐ REMOVE - Dependent Child Last Name	First Name	Social Security No.****	☐ Male ☐ Female DATE OF BIRTH / /	PCP Name / PCP or NPI No.*** Are you a current patient? ☐ Yes ☐ No
☐ ADD ☐ REMOVE - Dependent Child Last Name	First Name	Social Security No.****	☐ Male ☐ Female DATE OF BIRTH / /	PCP Name / PCP or NPI No.*** Are you a current patient? ☐ Yes ☐ No

PLEASE SEE SECTION 9 ON PAGE 2 FOR SUBSCRIBER SIGNATURE

* = Includes Party to a Civil Union or Domestic partner
** = Additional Documentation Required
*** = Physician Assistants & Nurse Practitioners are not valid
**** = SSN required age 45 and older (Federal mandate requires the collection of SSN)

SECTION 6 - DEPENDENTS AGE 19 OR OLDER

FOR FULL-TIME STUDENTS AGE 19 OR OLDER, PLEASE COMPLETE INFORMATION BELOW.

FOR INCAPACITATED DEPENDENTS AGE 19 OR OLDER, PLEASE CONTACT CUSTOMER SERVICE 1-800-247-2583 FOR FURTHER INSTRUCTIONS.

DEPENDENT NAME	SCHOOL NAME	CURRENT SEMESTER START DATE	ANTICIPATED GRADUATION DATE
DEPENDENT NAME	SCHOOL NAME	CURRENT SEMESTER START DATE	ANTICIPATED GRADUATION DATE
DEPENDENT NAME	SCHOOL NAME	CURRENT SEMESTER START DATE	ANTICIPATED GRADUATION DATE

I certify that the dependent(s) listed above are/is unmarried full-time student(s) earning at least 12 credit hours a semester.

SECTION 7 - OTHER INSURANCE INFORMATION

After you obtain health insurance coverage with us, will you or any of your dependents be covered with another health or dental insurance plan (Including Medicare)?

☐ Yes (If yes, please complete the applicable section below) ☐ If No (Go to SECTION 8)

MEDICARE

NAME of MEDICARE SUBSCRIBER	SOCIAL SECURITY NO.	MEDICARE/HIC NO.	PART A EFFECTIVE DATE	PART B EFFECTIVE DATE

HEALTH		DENTAL	
HEALTH INSURANCE COMPANY NAME		DENTAL INSURANCE COMPANY NAME	
ADDRESS		ADDRESS	
POLICY HOLDER NAME	POLICY/CERTIFICATE NO.	POLICY HOLDER NAME	POLICY/CERTIFICATE NO.
EFFECTIVE DATE / /	TYPE OF COVERAGE ☐ 1 PERSON ☐ 2 PERSON ☐ FAMILY	EFFECTIVE DATE / /	TYPE OF COVERAGE ☐ 1 PERSON ☐ 2 PERSON ☐ FAMILY

SECTION 8 - EXISTING HEALTH INSURANCE COVERAGE YOU INTEND TO REPLACE WITH THIS COVERAGE (NEW EMPLOYEES ONLY)

Do you have existing health care coverage that you are replacing with this coverage? ☐ Yes ☐ No If yes, you may be entitled to credit toward your waiting periods for some or all services. Please provide us with proof of your existing coverage, its effective date, termination date and the services it covers.

SECTION 9 - SUBSCRIBER SIGNATURE

I certify that the statements on this application and all information furnished by me are 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. If I apply for a managed care option, I (we) fully understand that in order to receive the Preferred Level of Benefits my (our) Primary Physician(s) must provide or preauthorize all medical and hospital care, except in life threatening emergencies while away from home and as specified in my (our) Certificate or Outline of Coverage.

SIGN HERE

SUBSCRIBER'S SIGNATURE X ______________________ DATE ____________

E-MAIL ADDRESS

You can visit our website at www.bcbsvt.com