

Submit one of three ways: email, fax, or mail.  
See page 2 for more information.

 Requested effective date  
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### Section 1: EMPLOYER/EMPLOYEE INFORMATION

<b>Employer name:</b>		<b>Employer type:</b>	
		<input type="checkbox"/> Licensed <input type="checkbox"/> Non-licensed <input type="checkbox"/> Confidential/Municipal <input type="checkbox"/> Private School/Other	
<b>Group/division #:</b> <small>(office use only)</small>		<b>Employment status:</b>	
		<input type="checkbox"/> Active <input type="checkbox"/> Continuation (COBRA)	
<b>Health plan selection:</b>			
<input type="checkbox"/> Platinum <input type="checkbox"/> Gold <input type="checkbox"/> Gold CDHP <input type="checkbox"/> Silver CDHP			
<b>Health coverage type:</b>			
<input type="checkbox"/> Employee only <input type="checkbox"/> Employee/spouse (including party to a civil union/domestic partner) <input type="checkbox"/> Employee/child(ren) <input type="checkbox"/> Family			
<b>Health care spending account:</b>			
<input type="checkbox"/> Health Reimbursement Arrangement (HRA): all plans <input type="checkbox"/> Health Savings Account (HSA): For Public Schools Silver CDHP Only <input type="checkbox"/> None/Opt-out			
<b>Last name:</b>		<b>First name:</b>	<b>Social Security number ****(SSN):</b>
<b>Mailing address:</b>			<b>PCP name</b> NPI No.***
<b>City:</b>		<b>State:</b>	<b>ZIP code:</b>
<b>Phone number:</b>		<b>Email address:</b>	
<b>Date of birth (DOB):</b>		<b>Gender:</b>	<b>Marital status:</b>
		<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Single <input type="checkbox"/> Married/party to a civil union <input type="checkbox"/> Domestic Partner**

### Section 2: NEW ENROLLMENT (Check one, then go to SECTION 4)

<input type="checkbox"/> Open enrollment	<input type="checkbox"/> New hire/re-hire	<input type="checkbox"/> Continuation of coverage (COBRA)	<input type="checkbox"/> Refusal	<input type="checkbox"/> Spouse turning age 65
<input type="checkbox"/> Transferred from another VEHI plan      Transferring from member ID no: _____				

### Section 3: CHANGE/CANCELLATION

<b>Change:</b>		Effective date ___/___/_____		<b>Cancel:</b>	
<input type="checkbox"/> Birth <input type="checkbox"/> Adoption placement date ___/___/_____ <input type="checkbox"/> Marriage/Civil Union <input type="checkbox"/> Divorce		<input type="checkbox"/> Address change <input type="checkbox"/> Name change <input type="checkbox"/> PCP change <input type="checkbox"/> Court ordered change** <input type="checkbox"/> Loss of coverage**		<input type="checkbox"/> Voluntary cancel (signature required) _____ <input type="checkbox"/> Left employment (group benefits manager signature) _____ <input type="checkbox"/> Other (explain) _____	

### Section 4: LIST ALL DEPENDENTS BELOW TO BE ADDED OR REMOVED

Dependent Information			**** Important note: SSN required for all members			Primary Care Provider (PCP) Information (required)		
<input type="checkbox"/> Add <input type="checkbox"/> Remove (Spouse/party to a civil union/domestic partner)	SSN***	Gender:	PCP Name	NPI No.***				
Last Name                      First Name	DOB	<input type="checkbox"/> Male	Are you a current patient? <input type="checkbox"/> Yes <input type="checkbox"/> No					
		<input type="checkbox"/> Female	<input type="checkbox"/> resides outside of BCBSVT provider network (no PCP required)					
<input type="checkbox"/> Add <input type="checkbox"/> Remove	SSN***	Gender:	PCP Name	NPI No.***				
Last Name                      First Name	DOB	<input type="checkbox"/> Male	Are you a current patient? <input type="checkbox"/> Yes <input type="checkbox"/> No					
		<input type="checkbox"/> Female	<input type="checkbox"/> resides outside of BCBSVT provider network (no PCP required)					
<input type="checkbox"/> Add <input type="checkbox"/> Remove	SSN***	Gender:	PCP Name	NPI No.***				
Last Name                      First Name	DOB	<input type="checkbox"/> Male	Are you a current patient? <input type="checkbox"/> Yes <input type="checkbox"/> No					
		<input type="checkbox"/> Female	<input type="checkbox"/> resides outside of BCBSVT provider network (no PCP required)					
<input type="checkbox"/> Add <input type="checkbox"/> Remove	SSN***	Gender:	PCP Name	NPI No.***				
Last Name                      First Name	DOB	<input type="checkbox"/> Male	Are you a current patient? <input type="checkbox"/> Yes <input type="checkbox"/> No					
		<input type="checkbox"/> Female	<input type="checkbox"/> resides outside of BCBSVT provider network (no PCP required)					

Please see section 6 on page 2 for employee signature

Employer name:	Employee name:
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### Section 5: OTHER INSURANCE INFORMATION

If 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 or Medicaid)?

Yes  No

MEDICAL	Insurance company (name and address)			DENTAL	Insurance company (name and address)		
	Policyholder name	Policy certificate no.	Group no.		Policyholder name	Policy certificate no.	Group no.
	Effective date	Type of coverage <input type="checkbox"/> 1-person <input type="checkbox"/> 2-person <input type="checkbox"/> Family			Effective date	Type of coverage <input type="checkbox"/> 1-person <input type="checkbox"/> 2-person <input type="checkbox"/> Family	

### Section 6: SUBSCRIBER INFORMATION

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 VT, 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 VT.

I UNDERSTAND THAT MY BENEFITS ARE GOVERNED BY THE PROVISIONS OF MY VEHI BENEFITS DESCRIPTION AND OUTLINE OF COVERAGE.

## SIGN HERE

► Employee's signature \_\_\_\_\_ Date \_\_\_\_\_ ◀

Return this form to your Central Office for processing. Central Office can submit one of three ways:

Email	asinbox@bcbsvt.com	Fax:	(802) 371-3329	Mail:	Blue Cross VT P.O. Box 186 Montpelier, VT 05601-0186
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## 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](http://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](http://bluecrossvt.org/privacypolicies).

### NOTICE: Discrimination is Against the Law

BlueCross and BlueShield of Vermont (Blue Cross) 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 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 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 [civilrightscoordinator@bcbsvt.com](mailto:civilrightscoordinator@bcbsvt.com)

If you believe that Blue Cross 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: Kieran D. Christianson, Civil Rights Coordinator, P.O. Box 186, Montpelier, VT 05601-0186, call (800) 247-2583, fax (802) 229-0511, or email [civilrightscoordinator@bcbsvt.com](mailto:civilrightscoordinator@bcbsvt.com). You can file a grievance in person, by mail, via fax, or by email. If you need help filing a grievance, Kieran D. Christianson, 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.medicare.gov/claims-appeals/how-to-file-a-complaint-grievance>



## For free language-assistance services, call (800) 247-2583

### ARABIC

للحصول على خدمات المساعدة اللغوية المجانية، اتصل  
(800) 247 2583. lilhusul ealaa khadmat almusaeadat allughawiat almajaaniat, atasal (800) 247-2583.

### CHINESE

如需免费语言协助服务，请致电，(800) 247-2583。Rú xū miǎnfèi yǔyán xiézhù fúwù, qǐng zhìdiàn (800) 247-2583.

### CUSHITE (OROMO)

Tajaajila gargaarsa afaanii bilisaa argachuuf, (800) 247-2583 bilbilii.

### FRENCH

Pour des services d'assistance linguistique gratuits, appelez le (800) 247-2583.

### GERMAN

Für kostenlose Sprachunterstützungsdienste rufen Sie (800) 247-2583 an.

### ITALIAN

Per i servizi di assistenza linguistica gratuiti, chiamare il numero (800) 247-2583.

### JAPANESE

無料の言語支援サービスについては、(800) 247-2583。Muryō no gengo shien sābisu ni tsuite wa ,(800) 247-2583 made o denwa kudasai.

### NEPALI

निःशुल्क भाषा-सहायता सेवाहरूको लागि, कल गर्नुहोस्, (800) 247-2583. Niḥśulka bhāṣā-sahāyatā sevāharūkō lāgi, kala garnuhōs (800) 247-2583.

### PORTUGUESE

Para serviços gratuitos de assistência linguística, ligue para (800) 247-2583.

### RUSSIAN

Чтобы получить бесплатную языковую помощь, позвоните по телефону (800) 247-2583.

### SERBO-CROATIAN (SERBIAN)

За бесплатне услуге језичке помоћи позовите (800) 247-2583. Za besplatne usluge jezičke pomoći pozovite (800) 247-2583.

### SPANISH

Para servicios gratuitos de asistencia lingüística, llame al (800) 247-2583.

### TAGALOG

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyong tulong sa wika nang walang bayad. Tumawag sa (800) 247-2583.

### THAI

สำหรับบริการช่วยเหลือด้านภาษาฟรี โทร.(800) 247-2583. Sāfirāb brikār ch̄wiyēlūx dān phās'ā frī thor (800) 247-2583.

### UKRAINIAN

Щоб отримати безкоштовні мовні послуги, телефонуйте (800) 247-2583. Shchob otrymaty bezkoshtovni movni posluhy, telefonuyte (800) 247-2583

### VIETNAMESE

Đối với các dịch vụ hỗ trợ ngôn ngữ miễn phí, hãy gọi (800) 247-2583.

If you are adding a dependent child, age 26 or older, contact customer service at (800) 344-6690 for further instructions.

\* = Includes Party to a Civil Union or Domestic partner

\*\* = Additional Documentation Required

\*\*\* = See our "Find-a-Doctor" tool at [bluecrossvt.org/find-doctor](http://bluecrossvt.org/find-doctor)

\*\*\*\* = SSN required for all members (Federal mandate requires the collection of SSN).