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 2 for more information.

VEHI
Enrollment and Change Form

vehi

Please provide all information and print in ink or type.

Requested effective date ___/___/___

Section 1: EMPLOYER/EMPLOYEE INFORMATION

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

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

☐ Open enrollment ☐ New hire/re-hire ☐ Continuation of coverage (COBRA) ☐ Refusal ☐ Spouse turning age 65

☐ Transferred from another VEHI plan Transferring from member ID no.: ____________________

Section 3: CHANGE/CANCELLATION

Change: Effective date ___/___/______

☐ Birth
☐ Adoption placement date ____/____/_______
☐ Marriage/Civil Union
☐ Divorce
☐ Address change
☐ Name change
☐ PCP change
☐ Court ordered change**
☐ Loss of coverage**

Cancel:

☐ Voluntary cancel (signature required) ____________________
☐ Left employment (group benefits manager signature) ____________________
☐ 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)
☐ Add ☐ Remove (Spouse/party to a civil union/domestic partner) Last Name First Name	SSN*** DOB	Gender: ☐ Male ☐ Female	PCP Name NPI No.*** Are you a current patient? ☐ Yes ☐ No ☐ resides outside of BCBSVT provider network (no PCP required)
☐ Add ☐ Remove Last Name First Name	SSN*** DOB	Gender: ☐ Male ☐ Female	PCP Name NPI No.*** Are you a current patient? ☐ Yes ☐ No ☐ resides outside of BCBSVT provider network (no PCP required)
☐ Add ☐ Remove Last Name First Name	SSN*** DOB	Gender: ☐ Male ☐ Female	PCP Name NPI No.*** Are you a current patient? ☐ Yes ☐ No ☐ resides outside of BCBSVT provider network (no PCP required)
☐ Add ☐ Remove Last Name First Name	SSN*** DOB	Gender: ☐ Male ☐ Female	PCP Name NPI No.*** Are you a current patient? ☐ Yes ☐ No ☐ resides outside of BCBSVT provider network (no PCP required)
☐ Add ☐ Remove Last Name First Name	SSN*** DOB	Gender: ☐ Male ☐ Female	PCP Name NPI No.*** Are you a current patient? ☐ Yes ☐ No ☐ resides outside of BCBSVT provider network (no PCP required)

Please see section 6 on page 2 for employee signature

Employer name:	Employee name:

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

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

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

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: Kienan 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. You can file a grievance in person, by mail, via fax, or by email. If you need help filing a grievance, Kienan 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 bilbili.

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 sēvāharūkō 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 serbisyo ng tulong sa wika nang walang bayad. Tumawag sa (800) 247-2583.

THAI
สำหรับบริการช่วยเหลือด้านภาษาฟรี โทร,(800) 247-2583. Ṣ̄ảh̄rạb brikār ch̀wyh̄elụ̄x d̂ān phās̄'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**
**** = SSN required for all members (Federal mandate requires the collection of SSN).