

Please submit this form to your Human
Resource Office for processing.

Enrollment and Change Form

for Association or Private/Independent School Employees

Requested effective date

Section 1: EMPLOYER/EMPLOYEE INFORMATION

Employer name:		Employer type: ☐ Private School/Independent ☐ Association	
Group/division #: (HR use only) 3160 - - - - -		Employment status: ☐ Active ☐ Continuation (COBRA)	
Health coverage type: ☐ Employee only ☐ Employee/spouse (including party to a civil union/domestic partner) ☐ Employee/child(ren) ☐ Family			
Health plan selection: ☐ Platinum ☐ Gold ☐ Gold CDHP ☐ Silver CDHP (see funding options below, check with Employer to confirm availability)			
Health care spending account: ☐ Health Reimbursement Arrangement (HRA): all plans ☐ Health Savings Account (HSA): (CDHP Plans only) ☐ None/Opt-out			
Last name:		First name:	Social Security number ****(SSN):
Mailing address:		PCP name NPI No.*** - - - - -	
City:	State:	ZIP code:	Are you a current patient? ☐ Yes ☐ No
Phone number:		Email address:	☐ resides outside of BCBSVT provider network (no PCP required)
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 __/__/__	Cancel:	Date of Cancellation __/__/__
☐ Birth	☐ Address change	☐ Voluntary cancel (signature required) _____	
☐ Adoption placement __/__/__	☐ Name change	☐ Left employment (group benefits manager signature) _____	
☐ Marriage/Civil Union __/__/__	☐ PCP change	☐ Other (explain) _____	
☐ Divorce __/__/__	☐ Court ordered change** __/__/__	Proof of other insurance is required to complete this request if submitted outside of groups Open Enrollment period. Please include documentation when returning the form.	
	☐ Loss of coverage** __/__/__		

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)	SSN***	Gender:	PCP Name
Last Name First Name	DOB	☐ Male	NPI No.*** - - - - -
		☐ Female	Are you a current patient? ☐ Yes ☐ No
			☐ resides outside of BCBSVT provider network (no PCP required)
☐ Add ☐ Remove	SSN***	Gender:	PCP Name
Last Name First Name	DOB	☐ Male	NPI No.*** - - - - -
		☐ Female	Are you a current patient? ☐ Yes ☐ No
			☐ resides outside of BCBSVT provider network (no PCP required)
☐ Add ☐ Remove	SSN***	Gender:	PCP Name
Last Name First Name	DOB	☐ Male	NPI No.*** - - - - -
		☐ Female	Are you a current patient? ☐ Yes ☐ No
			☐ resides outside of BCBSVT provider network (no PCP required)
☐ Add ☐ Remove	SSN***	Gender:	PCP Name
Last Name First Name	DOB	☐ Male	NPI No.*** - - - - -
		☐ Female	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:
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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 ☐ 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 _____ ◀

FOR OFFICE USE ONLY

Email: asinbox@bcbsvt.com	Fax: (802) 371-3329	Mail: Blue Cross VT P.O. Box 186 Montpelier, VT 05601-0186
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If you are adding a dependent child, age 26 or older, contact customer service at (800) 344-6690 (TTY/TDD: 711) 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).