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.

Small Group Coverage

Enrollment and Change Form

Please provide all information and print in ink or type.

Requested effective date ____/____/____

Section 1: EMPLOYEE INFORMATION

Employer Group name:

Group/account no.:

Plan Selection:

☐ Platinum ☐ Gold ☐ Silver ☐ Bronze ☐ BRONZE *(without Rx MOOP)*

☐ Silver CDHP *(Consumer-Directed Health Plan)* ☐ Bronze CDHP

Blue Rewards Health and Wellness Program℠ Plans:

☐ Blue Rewards Gold ☐ Blue Rewards Silver ☐ Blue Rewards Bronze

☐ Blue Rewards Gold CDHP ☐ Blue Rewards Bronze CDHP

Last name:	First name:	Social Security number**** (SSN):	
Mailing address:	City:	State:	ZIP code:
Phone number:	Email address:	Primary Care Physician (PCP) name, or NPI number: Are you a current patient? ☐ Yes ☐ No	
Date of birth (DOB): / Sex: ☐ Male ☐ Female	Marital status: ☐ Single ☐ Domestic Partner** ☐ Married/party to a civil union	Employment status: ☐ Active ☐ Retired ☐ Continuation	

Health coverage type: ☐ Employee only ☐ Employee/spouse *(including party to a civil union/domestic partner)* ☐ Employee/children ☐ Family

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

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

☐ Transferred from another BCBSVT plan Transferring from certificate no. ______________________________

Section 3: CHANGE/CANCELLATION

Change: *Effective date* ____/____/_____

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

Cancel: *Date of cancellation* ____/____/_____

☐ 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: federal law mandates our collection of SSN for all members .

Primary Care Physician (PCP) Information *(If Managed Care)*

Dependent	SSN / DOB	Sex	PCP
☐ Add ☐ Remove *(Spouse/party to a civil union/domestic partner)* Last Name First Name Phone Same as employee? ☐ Yes ☐ No	SSN**** DOB	Sex ☐ Male ☐ Female	PCP Name NPI No.*** Are you a current patient? ☐ Yes ☐ No
☐ Add ☐ Remove Last Name First Name Phone Same as employee? ☐ Yes ☐ No	SSN**** DOB	Sex ☐ Male ☐ Female	PCP Name NPI No.*** Are you a current patient? ☐ Yes ☐ No
☐ Add ☐ Remove Last Name First Name Phone Same as employee? ☐ Yes ☐ No	SSN**** DOB	Sex ☐ Male ☐ Female	PCP Name NPI No.*** Are you a current patient? ☐ Yes ☐ No
☐ Add ☐ Remove Last Name First Name Phone Same as employee? ☐ Yes ☐ No	SSN**** DOB	Sex ☐ Male ☐ Female	PCP Name NPI No.*** Are you a current patient? ☐ Yes ☐ No

Please see section 6 on page 2 for subscriber signature

Group 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 *(please complete the applicable section below)* ☐ No

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

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

Section 6: SUBSCRIBER SIGNATURE

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

SIGN HERE

▶ Employee's signature _____ date _____ ◀

Submit one of three ways:

Email: asinbox@bcbsvt.com

Fax: (802) 371-3329

Mail: Blue Cross and Blue Shield of Vermont
P.O. Box 186
Montpelier, VT 05601-0186

NOTICE: Discrimination is Against the Law

Blue Cross and Blue Shield of Vermont (BCBSVT) 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.

BCBSVT 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).

BCBSVT 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, please call (800) 247-2583. If you would like to file a grievance because you believe that BCBSVT has failed to provide services or discriminated on the basis of race, color, national origin, age, disability, gender identity or sex, contact:

Civil Rights Coordinator
Blue Cross and Blue Shield of Vermont
PO Box 186
Montpelier, VT 05601
(802) 371-3394
TDD/TTY: (800) 535-2227
civilrightscoordinator@bcbsvt.com

You can file a grievance by mail, or email at the contacts above. If you need assistance, our 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 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
Office for Civil Rights
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
(800) 368-1019
(800) 537-7697 (TDD)

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

ARABIC
للحصول على خدمات المساعدة اللغوية المجانية، اتصل على الرقم (800) 247-2583.

CHINESE
如需免費語言協助服務，請致電 (800) 247-2583。

CUSHITE (OROMO)
Tajaajila gargaarsa afaan hiikuu kaffaltii malee argachuuf (800) 247-2583 bilbilaa.

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

GERMAN
Kostenlose fremdsprachliche Unterstützung erhalten Sie unter (800) 247-2583.

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

JAPANESE
無料の通訳サービスのご利用は、(800) 247-2583までお電話ください。

NEPALI
नःशुल्क भाषा सहायता सेवाहरूका लागि, (800) 247-2583 मा कल गर्नुहोस्।

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

RUSSIAN
Чтобы получить бесплатные услуги переводчика, позвоните по телефону (800) 247-2583.

SERBO-CROATIAN (SERBIAN)
Za besplatnu uslugu prevođenja, pozovite na broj (800) 247-2583.

SPANISH
Para servicios gratuitos de asistencia con el idioma, llame al (800) 247-2583.

TAGALOG
Para sa libreng mga serbisyo ng tulong pangwika, tumawag sa (800) 247-2583.

THAI
สำหรับการให้บริการความช่วยเหลือด้านภาษาฟรี โทร (800) 247-2583

VIETNAMESE
Để biết các dịch vụ hỗ trợ ngôn ngữ miễn phí, hãy gọi số (800) 247-2583.

If you are adding a dependent child, age 26 or older, contact customer service at (800) 247-2583 for further instructions.

* = Includes Party to a Civil Union or Domestic partner

** = Additional Documentation Required

*** = See our "Find-a-Doctor" tool at **www.bcbsvt.com/findadoctor**

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