

Large Group Coverage

Enrollment and Change Form

Please provide all information and print in ink or type.

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

Group name:		Plan Selection:		<input type="checkbox"/> Comprehensive	<input type="checkbox"/> Comprehensive CDHP
Group/account no.:		<input type="checkbox"/> J Plan	<input type="checkbox"/> Vermont Freedom Plan (PPO)	<input type="checkbox"/> Vermont Health Partnership (POS)	
		<input type="checkbox"/> EPO (PCP)	<input type="checkbox"/> EPO	<input type="checkbox"/> Select (HMO)	
		<input type="checkbox"/> BlueCare (HMO)	<input type="checkbox"/> BlueCare Access (HMO)		
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? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Date of birth (DOB):	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Marital status: <input type="checkbox"/> Single <input type="checkbox"/> Widowed	Employment status:		
		<input type="checkbox"/> Married/party to a civil union <input type="checkbox"/> Domestic Partner**	<input type="checkbox"/> Active	<input type="checkbox"/> Retired	<input type="checkbox"/> Continuation
Health coverage type: <input type="checkbox"/> Employee only <input type="checkbox"/> Employee/spouse (including party to a civil union/domestic partner) <input type="checkbox"/> Employee/child <input type="checkbox"/> Family					

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

<input type="checkbox"/> New group	<input type="checkbox"/> Open enrollment	<input type="checkbox"/> New hire/re-hire	<input type="checkbox"/> Continuation of coverage (COBRA/VIPER)	<input type="checkbox"/> Refusal	<input type="checkbox"/> Spouse turning age 65
<input type="checkbox"/> Transferred from another BCBSVT plan Transferring from certificate no. _____					

Section 3: CHANGE/CANCELLATION

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

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 over 45.		Primary Care Physician (PCP) Information (If Managed Care)	
<input type="checkbox"/> Add <input type="checkbox"/> Remove (Spouse/party to a civil union/domestic partner) Last Name First Name	SSN****	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	PCP Name	NPI No.***
	DOB		Are you a current patient? <input type="checkbox"/> Yes <input type="checkbox"/> No	
<input type="checkbox"/> Add <input type="checkbox"/> Remove Last Name First Name	SSN****	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	PCP Name	NPI No.***
	DOB		Are you a current patient? <input type="checkbox"/> Yes <input type="checkbox"/> No	
<input type="checkbox"/> Add <input type="checkbox"/> Remove Last Name First Name	SSN****	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	PCP Name	NPI No.***
	DOB		Are you a current patient? <input type="checkbox"/> Yes <input type="checkbox"/> No	
<input type="checkbox"/> Add <input type="checkbox"/> Remove Last Name First Name	SSN****	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	PCP Name	NPI No.***
	DOB		Are you a current patient? <input type="checkbox"/> Yes <input type="checkbox"/> No	
<input type="checkbox"/> Add <input type="checkbox"/> Remove Last Name First Name	SSN****	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	PCP Name	NPI No.***
	DOB		Are you a current patient? <input type="checkbox"/> Yes <input type="checkbox"/> No	

Please see section 6 on page 2 for subscriber signature

Group name:	Employee name:
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Section 5: OTHER INSURANCE INFORMATION

After you obtain health insurance coverage with us, will you or any of your dependents be covered by Medicare? Yes (please complete the applicable section below) No

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 Blue Shield of Vermont 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) 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 age 45 and older (Federal mandate requires the collection of SSN)