BlueCross BlueShield of Vermont
An Independent Licensee of the Blue Cross and Blue Shield Association.

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 ___/___/___

Section 1: EMPLOYER/EMPLOYEE INFORMATION

Group name:

Group/account no.:

Plan Selection: ☐ Comprehensive ☐ Comprehensive CDHP ☐ J Plan ☐ Vermont Freedom Plan (PPO) ☐ Vermont Health Partnership (POS) ☐ EPO (PCP) ☐ EPO ☐ Select (HMO) ☐ BlueCare (HMO) ☐ 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? ☐ Yes ☐ No	
Date of birth (DOB): Gender: ☐ Male ☐ Female	Marital status: ☐ Single ☐ Widowed ☐ Married/party to a civil union ☐ Domestic Partner**	Employment status: ☐ Active ☐ Retired ☐ Continuation	

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

☐ 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 over 45.

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

Dependent	SSN / DOB	Gender	PCP
☐ 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
☐ Add ☐ Remove Last Name First Name	SSN**** DOB	Gender ☐ Male ☐ Female	PCP Name NPI No.*** Are you a current patient? ☐ Yes ☐ No
☐ Add ☐ Remove Last Name First Name	SSN**** DOB	Gender ☐ Male ☐ Female	PCP Name NPI No.*** Are you a current patient? ☐ Yes ☐ No
☐ Add ☐ Remove Last Name First Name	SSN**** DOB	Gender ☐ Male ☐ Female	PCP Name NPI No.*** Are you a current patient? ☐ Yes ☐ No
☐ Add ☐ Remove Last Name First Name	SSN**** DOB	Gender ☐ Male ☐ Female	PCP Name NPI No.*** Are you a current patient? ☐ Yes ☐ No
☐ Add ☐ Remove Last Name First Name	SSN**** DOB	Gender ☐ 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

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:	Fax:	Mail:
asinbox@bcbsvt.com	(802) 371-3329	Blue Cross Blue Shield of Vermont P.O. Box 186 Montpelier, VT 05601-0186

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)