NEW GROUP CHECKLIST

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

☑ Please return the following items to BCBSVT for new group enrollment:

☐ Completed and signed Group Enrollment Agreement Form.

☐ Completed Small Group Certification form including the Employee Census Information on side two.

☐ Provide proof of business:

IF YOU HAVE ...	PROVIDE ...
...filed business taxes	■ Vermont Quarterly Wage Report (C-101)
...NOT filed business taxes	■ most recent payroll register *OR* ■ letter Indicating the official start date of your business *AND* a copy of your state of Vermont Trade Name Registration form *OR* ■ Certificate of Authority form

☐ Completed Small Group Coverage Enrollment and Change Form for each employee enrolling in a Qualified Health Plan.

Each subscriber and dependent must select a participating Primary Care Physician (Nurse Practitioners, Physician's Assistants, Specialists and facilities are NOT acceptable).

☐ A check for your first month's premium, made payable to Blue Cross and Blue Shield of Vermont.

☐ Enrollees can complete a Continuity of Care form if they are being treated for a life threatening /disabling degenerative condition, are In their second or third trimester of pregnancy, have an upcoming surgery OR are on a medication for which prior approval has been given by the previous carrier.

☐ Employers must provide a copy of the Summary of Benefits and Coverage (SBC) to all eligible employees 30 days prior to effective date or within seven days of election of new coverage. To obtain a copy of your SBC, please contact Consumer & Business Support Services (CBSS) at **(800) 255-4550** or via email at **consumersupport@bcbsvt.com**. Your SBC can also be found by visiting our website at **http://www.bcbsvt.com/2019SBC**.

GROUP ENROLLMENT AGREEMENT

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

GROUP NAME (COMPANY NAME)			EFFECTIVE DATE
PHYSICAL ADDRESS (VERMONT)			PHONE
CITY	STATE	ZIP	FAX
NATURE OF BUSINESS	SIC CODE		FEDERAL TAX ID #
MAILING AND BILLING ADDRESS (IF OTHER THAN PHYSICAL ADDRESS)			
CITY	STATE	ZIP	
GROUP BENEFIT ADMINISTRATOR	TITLE		PHONE
EMAIL			FAX
ADDITIONAL CONTACT	TITLE		PHONE
EMAIL			FAX

Group census details

Total number of employees _____

Probationary period (no more than 90 days) New hires _____ days New rehires _____ days

Health equity account with integrated claims feed (no additional cost)

☐ Health savings account ☐ Health reimbursement arrangement

Return to:

Consumer and Business Support Services
Blue Cross and Blue Shield of Vermont
P.O. Box 186
Montpelier, VT 05601-0186

284.295 (8/17)

SMALL GROUP CERTIFICATION:
NEW GROUP

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

GROUP NAME

PHYSICAL ADDRESS

NUMBER OF EMPLOYEES ON PAYROLL

MAILING ADDRESS

GROUP E-MAIL

TAXPAYER ID NUMBER

Company minimum eligibility policy for health insurance IS:

_____ hours per week.

(required, even if only one employee participates)

I. EMPLOYEE CENSUS

As of 2016 the Affordable Care act defines a Small Employer as an entity with up to 100 full-time equivalent employees. To calculate the number of employees, include all employees that work full-time. Full-time, for this purpose, is defined as an employee that works at least 30 hours per week, or 130 hours in a calendar month. Fulltime equivalents equal the total part-time employee hours worked in a month divided by 120. Those numbers are added together give the monthly number. The 12 month totals are then averaged for the final count. Employers with less than 100 full-time equivalents are considered a small group and are allowed to purchase a Qualified Health Plan.

II. PROOF OF BUSINESS/INSURANCE

When returning your Small Group Certification Form you must include your Employer's Quarterly Wage and Contribution Report. Please indicate terminated, seasonal and part-time employees and the number of hours worked per week by each employee. You may remove Social Security numbers and financial information. If you are not required to file an Employer's Quarterly Wage and Contribution Report (Form C-1 01) with the Vermont Department of Employment and Training, or with any other state in which you do business, please submit one of the following: IRS Schedule C (Proprietorship); IRS Schedule SE (Self Employed); or IRS Schedule K-1 (Partnership or "S" Corporation).

III. CERTIFICATION

I verify that I have completed the Census information requested on the back of this form. I certify that I qualify as a Small Employer as described in section I. and have 100 or fewer full-time and full-time equivalent employees as calculated pursuant to IRS code §4890H(c)(2). I further certify that if I am required to file an "Employer's Quarterly Wage and Contribution Report" with the Department of Employment and Training I have attached a copy of the most recent report to this form or I am a self-employed proprietor and I have attached one of the following: IRS Schedule C (Proprietorship), IRS Schedule SE (Self-Employed) or IRS Schedule K1 (Partnership or "S" Corporation).

I certify that the information provided above is true and complete. I understand that if the above information is incomplete, untrue or is not provided in a timely manner, then group health benefits do not have to be offered or continued.

If all of the requested information is NOT complete, this form will be returned to you.

SIGNATURE OF OFFICER, PARTNER OR OWNER

DATE

SIGNATURE OF OFFICER, PARTNER OR OWNER

DATE

Return to:

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

or FAX: (802) 371-3719

or e-mail: consumersupport@bcbsvt.com

652.01C (8/17)

EMPLOYEE CENSUS INFORMATION

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

Please complete the following census OR include all of the requested information on the attached copy of your most recent Quarterly Wage and Contribution Report. Census must include current active employees, terminated employees included on the insurance under VIPER/COBRA, and retirees. List of current active employees should include: the owner(s), officer(s), manager(s) and employee(s) of the employer and the partners, if the employer is a partnership. The individuals on this list should match those listed on the Quarterly Wage Report that you are providing to us. If you're a business owner, please complete the form listing yourself as an employee.

Please use the following letters to complete the "EMPLOYMENT STATUS" column below:

- F: Full-time employee
- P/E: Part-time or Seasonal employee, eligible for benefits
- P/I: Part-time or Seasonal employee, ineligible for benefits
- U: Union employee participating in an employee welfare arrangement established pursuant to a collective bargaining agreement
- C: Continuee under State or Federal Law (VIPER/COBRA)
- R: Retiree, eligible for benefits
- T: Terminated employee

EMPLOYEE NAME: LAST NAME, FIRST INITIAL	HIRE DATE (IF WITHIN PAST 12 MOS.)	NUMBER OF HOURS WORKED PER WEEK	EMPLOYMENT STATUS	STATE WHERE EMPLOYED (IF OTHER THAN VT.)
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				
11.				
12.				
13.				
14.				
15.				
16.				
17.				
18.				
19.				
20.				

BlueCross BlueShield of Vermont

An Independent Licensee of the Blue Cross and Blue Shield Association.

Please provide all information and print in ink or type.

2019 coverage election form

Qualified health plan (QHP) coverage election form for small groups

Requested effective date / /

Section 1: GROUP INFORMATION

Group name:	Group Number
Group Benefit Administrator's name:	

Section 2: PLAN SELECTION

Select from the options listed below *(Choose up to 13 different plan options)*

Standard Plans					Standard CDHP Plans		Blue Rewards* Plans			Blue Rewards* CDHP Plans		
Platinum	Gold	Silver	Bronze	Bronze *without Rx MOOP*	Silver CDHP	Bronze CDHP	Blue Rewards Gold	Blue Rewards Silver	Blue Rewards Bronze	Blue Rewards Gold CDHP	Blue Rewards Silver CDHP	Blue Rewards Bronze CDHP
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Stacked Deductibles—Plan pays for an individual once the individual deductible is met (including family plans)					Aggregate Deductibles— Full, single or entire family deductible must be satisfied before benefits are paid.							

Employers are responsible to provide their employees with a **Summary of Benefits and Coverage** (SBC) which can be found on our website at: **www.bcbsvt.com/qhp**.

- ☐ I found the SBC on the website and will provide them to my employees
- ☐ Email the SBC to me at _____
- ☐ Mail a copy to me at the billing address on file

Section 3: BROKER / AGENT / PRODUCER *(if applicable)*

☐ Using a broker / agent / producer.
If you are using a broker please list them below. *By completing the information below you are listing the broker as an authorized contact for your group.*

Broker Name:	Agency Name:

Section 4: SIGNATURE

SIGN HERE

▶ Group Benefit Manager's signature *(required)* _____ date _____ ◀

Please return this form to: Blue Cross and Blue Shield of Vermont (BCBSVT), P.O. Box 186, Montpelier, VT 05601-0186.

Blue Rewards Plans include a $300 wellness incentive for each adult (21 and over) on the policy. See **www.bcbsvt.com/bluerewards** for additional details.

CDHP: Consumer-Directed Health Plan

Aggregate Deductible: Full single or entire family deductible must be satisfied before benefits are paid.

Stacked Deductible: Plan pays for an individual once the individual deductible is met (including family plans)

Regardless of all other cost-sharing, if one individual's out-of-pocket costs reach $7,900 in a year, we begin paying 100 percent of the allowed amount for that person's services and supplies.

For assistance, please call our sales consultants at (800) 255-4550, Monday through Friday, 8 a.m. to 4:30 p.m.

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

निःशुल्क 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.

We'll see you through. (800) 255-4550 | www.bcbsvt.com

BlueCross BlueShield of Vermont

An independent licensee of the Blue Cross and Blue Shield Association.

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 Number/Division:

Standard Plans:
☐ 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 Silver CDHP ☐ Blue Rewards Bronze CDHP

Last name:	First name:	Social Security number**** (SSN):	
Mailing address:	City:	State:	ZIP code:
Physical 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

Dependent Information	SSN / DOB	Sex	PCP Information
☐ 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 *(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 *(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 *(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

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

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(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.

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

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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
निःशुल्क 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)