

Submit one of three ways: email, fax, or mail.
See page 2 for more information.

Requested effective date / /

Section 1: EMPLOYER/EMPLOYEE INFORMATION					
Employer name:		EPO (PCP) Selection: <input type="checkbox"/> Platinum <input type="checkbox"/> Gold <input type="checkbox"/> Gold CDHP <input type="checkbox"/> Silver CDHP			
Group/account no.:		Health care spending accounts: <input type="checkbox"/> Health Reimbursement Arrangement (HRA): <i>all plans</i> <input type="checkbox"/> None <input type="checkbox"/> Health Savings Account (HSA): <i>Gold CDHP and Silver CDHP only</i>			
Last name:		First name:		Social Security number**** (SSN):	
Mailing address:				PCP Name NPI No.***	
City:		State:		ZIP code:	
Phone number:		Email address:		Are you a current patient? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> resides outside of BCBSVT provider network (<i>no PCP required</i>)	
Date of birth (DOB):	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Marital status: <input type="checkbox"/> Single <input type="checkbox"/> Married/party to a civil union <input type="checkbox"/> Domestic Partner**		Employment status: <input type="checkbox"/> Active <input type="checkbox"/> Continuation (COBRA)	
Health coverage type: <input type="checkbox"/> Employee only <input type="checkbox"/> Employee/spouse (<i>including party to a civil union/domestic partner</i>) <input type="checkbox"/> Employee/child(ren) <input type="checkbox"/> Family					

Section 2: NEW ENROLLMENT <i>(Check one, then go to SECTION 4)</i>					
<input type="checkbox"/> Open enrollment	<input type="checkbox"/> New hire/re-hire	<input type="checkbox"/> Continuation of coverage (COBRA)		<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:	
<input type="checkbox"/> Birth	<input type="checkbox"/> Address change	<input type="checkbox"/> Voluntary cancel (<i>signature required</i>) _____	Date of cancellation ____/____/____		
<input type="checkbox"/> Adoption placement date ____/____/____	<input type="checkbox"/> Name change	<input type="checkbox"/> Left employment (<i>group benefits manager signature</i>) _____			
<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			Primary Care Provider (PCP) Information <i>(required)</i>		
**** Important note: SSN required for all members.					
<input type="checkbox"/> Add <input type="checkbox"/> Remove <i>(Spouse/party to a civil union/domestic partner)</i>	Last Name		SSN****	Gender	PCP Name NPI No.***
	First Name	DOB	<input type="checkbox"/> Male <input type="checkbox"/> Female	Are you a current patient? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> resides outside of BCBSVT provider network (<i>no PCP required</i>)	
<input type="checkbox"/> Add <input type="checkbox"/> Remove	Last Name		SSN****	Gender	PCP Name NPI No.***
	First Name	DOB	<input type="checkbox"/> Male <input type="checkbox"/> Female	Are you a current patient? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> resides outside of BCBSVT provider network (<i>no PCP required</i>)	
<input type="checkbox"/> Add <input type="checkbox"/> Remove	Last Name		SSN****	Gender	PCP Name NPI No.***
	First Name	DOB	<input type="checkbox"/> Male <input type="checkbox"/> Female	Are you a current patient? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> resides outside of BCBSVT provider network (<i>no PCP required</i>)	
<input type="checkbox"/> Add <input type="checkbox"/> Remove	Last Name		SSN****	Gender	PCP Name NPI No.***
	First Name	DOB	<input type="checkbox"/> Male <input type="checkbox"/> Female	Are you a current patient? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> resides outside of BCBSVT provider network (<i>no PCP required</i>)	
<input type="checkbox"/> Add <input type="checkbox"/> Remove	Last Name		SSN****	Gender	PCP Name NPI No.***
	First Name	DOB	<input type="checkbox"/> Male <input type="checkbox"/> Female	Are you a current patient? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> resides outside of BCBSVT provider network (<i>no PCP required</i>)	

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 (please complete the applicable section below) 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 <input type="checkbox"/> 1-person <input type="checkbox"/> 2-person <input type="checkbox"/> Family		Effective date		Type of coverage <input type="checkbox"/> 1-person <input type="checkbox"/> 2-person <input type="checkbox"/> 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 VEHI BENEFITS DESCRIPTION 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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NOTICE: Discrimination is Against the Law

Blue Cross and Blue Shield of Vermont (BCBSVT) complies with applicable federal and state civil rights laws and does 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
civilrightscordinator@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

สำหรับบริการให้บริการความช่วยเหลือด้านภาษาฟรี 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 for all members

(Federal mandate requires the collection of SSN)