BlueCross BlueShield of Vermont

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

Broker Authorization Form
For QHP Groups

Group #________________

Group Name __________________________________

Effective ____/____/20____, we wish to name ______________________ as an authorized contact for our group plan.

As such, we authorize _________________________ to have access to our membership and billing records and speak with Blue Cross and Blue Shield of Vermont on our behalf. This authorization is to remain in place until we provide written notification to Blue Cross and Blue Shield of Vermont directing them to remove the above named authorized contact.

We understand that the execution of this form, consistent with federal and state law, does not authorize the individual identified herein to obtain individual protected health information of a specific employee without that employee's consent other than information which is necessary to manage enrollment and billing.

___________________________________ ____________________

Authorized Group Representative Date

P.O. Box 186 · Montpelier, VT 05601-0186
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