BlueCross BlueShield of Vermont

An Independent Licensee of the Blue Cross and Blue Shield Association

GROUP ENROLLMENT/CHANGE FORM

PLEASE TYPE OR PRINT (IN PEN)

Employee ID: ____________

Send completed forms to Human Resources via uvm.edu/filetransfer to HRinfo@uvm.edu.

REQUESTED EFFECTIVE DATE / /

SECTION 1 - EMPLOYER/EMPLOYEE INFORMATION

☐ VHP - All New Hires, Active Employees and Retirees under age 65

EMPLOYER NAME

ACCOUNT NO. (Human Resources to Complete)

SOCIAL SECURITY NO. | LAST NAME | FIRST NAME

MAILING ADDRESS | CITY | STATE | ZIP CODE

CONTACT NUMBER | E-MAIL ADDRESS (REQUIRED)

EMPLOYMENT STATUS: ☐ ACTIVE ☐ RETIRED ☐ CONTINUATION

DATE HIRED/REHIRED/or BECAME FULL TIME

MARITAL STATUS: ☐ SINGLE ☐ MARRIED/PARTY TO A CIVIL UNION ☐ DOMESTIC PARTNER** ☐ DIVORCED ☐ WIDOWED

HEALTH COVERAGE TYPE (*Includes Party to a Civil Union or Domestic Partner): ☐ EMPLOYEE ONLY ☐ EMPLOYEE/SPOUSE* ☐ EMPLOYEE/CHILD ☐ EMPLOYEE/CHILDREN ☐ FAMILY

SECTION 2 - NEW ENROLLMENT (Check one, then go to SECTION 5)

☐ NEW HIRE ☐ RE-HIRE ☐ MEDICOMP SUPPLEMENT** (Attach copy of Medicare Card) ☐ SPOUSE TURNING AGE 65 ☐ OPEN ENROLLMENT ☐ CONTINUATION OF COVERAGE (COBRA/VIPER)

☐ REFUSAL ☐ NEW GROUP ☐ TRANSFERRED FROM ANOTHER BCBSVT PLAN Transferring From Certificate No. ____________

SECTION 3 - CHANGE (Check all that apply)

DATE OF EVENT ____________ REASON FOR CHANGE EVENT ☐ BIRTH ☐ ADOPTION ☐ MARRIAGE/CIVIL UNION ☐ DIVORCE ☐ DEATH

☐ LOSS OF COVERAGE** ☐ ENTER/DISCHARGE FROM MILITARY ☐ COURT ORDERED CHANGE** ☐ ADD/REMOVE SPOUSE/PARTY TO CIVIL UNION OR DEPENDENT (List in SECTION 5)

☐ ADDRESS CHANGE ☐ NAME CHANGE ☐ PCP CHANGE ☐ OTHER (explain) ____________

SECTION 4 - POLICY CANCELLATION - Signature Required

☐ VOLUNTARY CANCEL (Subscriber Signature)

☐ LEFT EMPLOYMENT (Group Benefits Manager Signature)

☐ CANCEL CONTINUATION COVERAGE (Subscriber or Group Benefits Manager)

☐ OTHER, explain____________ (Subscriber Signature)

SIGN HERE BELOW:

X ____________

SECTION 5 - LIST ALL MEMBERS BELOW TO BE ADDED OR REMOVED

IMPORTANT NOTE: Federal Law mandates our collection of Social Security Numbers (SSN).

If you are adding a dependent child, age 26 or older, contact Customer Service (800) 247-2583 for further instructions.

MEMBER INFORMATION				PRIMARY CARE PHYSICIAN (PCP) INFORMATION (IF MANAGED CARE)
☐ ADD ☐ REMOVE - **Subscriber** LAST NAME	FIRST NAME	SSN**** DOB	☐ Male ☐ Female	PCP Name / PCP or NPI No.*** Are you a current patient? ☐ Yes ☐ No
☐ ADD ☐ REMOVE - **Spouse** LAST NAME	FIRST NAME	SSN**** DOB	☐ Male ☐ Female	PCP Name / PCP or NPI No.*** Are you a current patient? ☐ Yes ☐ No
☐ ADD ☐ REMOVE - **Dependent Child** ☐ Incapacitated dependent 26/older LAST NAME	FIRST NAME	SSN DOB	☐ Male ☐ Female	PCP Name / PCP or NPI No.*** Are you a current patient? ☐ Yes ☐ No
☐ ADD ☐ REMOVE - **Dependent Child** ☐ Incapacitated dependent 26/older LAST NAME	FIRST NAME	SSN DOB	☐ Male ☐ Female	PCP Name / PCP or NPI No.*** Are you a current patient? ☐ Yes ☐ No
☐ ADD ☐ REMOVE - **Dependent Child** ☐ Incapacitated dependent 26/older LAST NAME	FIRST NAME	SSN DOB	☐ Male ☐ Female	PCP Name / PCP or NPI No.*** Are you a current patient? ☐ Yes ☐ No
☐ ADD ☐ REMOVE - **Dependent Child** ☐ Incapacitated dependent 26/older LAST NAME	FIRST NAME	SSN DOB	☐ Male ☐ Female	PCP Name / PCP or NPI No.*** Are you a current patient? ☐ Yes ☐ No

PLEASE SEE SECTION 8 ON PAGE 2 FOR SUBSCRIBER SIGNATURE

** = Additional Documentation Required

*** = Physician Assistants & Nurse Practitioners are not valid

**** = SSN required age 45 and older (Federal mandate requires the collection of SSN)

Employee ID:_____

SECTION 6 - OTHER INSURANCE INFORMATION

After 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)?

☐ Yes (If yes, please complete the applicable section below) ☐ If No (Go to SECTION 8)

MEDICARE

NAME of MEDICARE SUBSCRIBER	SOCIAL SECURITY NO.	MEDICARE/HIC NO.	PART A EFFECTIVE DATE	PART B EFFECTIVE DATE

HEALTH

HEALTH INSURANCE COMPANY NAME	
ADDRESS	
POLICY HOLDER NAME	POLICY/CERTIFICATE NO.
EFFECTIVE DATE / /	TYPE OF COVERAGE ☐ 1 PERSON ☐ 2 PERSON ☐ FAMILY

DENTAL

DENTAL INSURANCE COMPANY NAME	
ADDRESS	
POLICY HOLDER NAME	POLICY/CERTIFICATE NO.
EFFECTIVE DATE / /	TYPE OF COVERAGE ☐ 1 PERSON ☐ 2 PERSON ☐ FAMILY

SECTION 7 - EXISTING HEALTH INSURANCE COVERAGE YOU INTEND TO REPLACE WITH THIS COVERAGE (NEW EMPLOYEES ONLY)

Do you have existing health care coverage that you are replacing with this coverage? ☐ Yes ☐ No

SECTION 8 - SUBSCRIBER SIGNATURE

I certify that the statements on this application and all information furnished by me are 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

▶ SUBSCRIBER'S SIGNATURE X_____ DATE _____ ◀

You can visit our website at www.bcbsvt.com

Updated October 2023