Blue Edge Business Group Enrollment Agreement

GROUP DEMOGRAPHICS

Group Name ____ Effective Date ____________

Physical Address (Street) _______________________________ Phone __________________

City ____________________ State ________ Zip Code _________ Fax ____________________

Nature of Business __________________ SIC Code _________ Federal Tax ID# ______________

Mailing and Business Address (if different than physical)

Street ___________________________ City ________________ State ____ Zip Code _________

GROUP CONTACT INFORMATION

Group Contact (Name) ____________________________ Title _____________________ Phone _________________

Email ____ Fax __________________

Additional Contact ________________________________ Title ____________________ Phone _________________

Email ____ Fax __________________

Total Number of Employees ____________________ Prior Carrier ____

ELIGIBILITY

The waiting period (cannot be more than 90 days) for rehires is _______ days and for new hires is ______ days

Eligibility hours: To be eligible for benefits, employees must work _____ or more hours per week (cannot be less than 17.5 or greater than 30)

PLAN SELECTION

Copay 1:	Copay 2:	CDHP 1:	CDHP 2:
$30/$50 OV *$850/$1,700 deductible* *30% coinsurance* ☐	*$30/$50 OV* *$3,000/$6,000 deductible* *then copays* ☐	*$2,750/$5,500 deductible* *0% coinsurance* ☐	*$5,250/$10,500* *50% coinsurance* ☐

BlueCross BlueShield of Vermont

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

REIMBURSEMENT ACCOUNTS

HRA: Yes ☐ No ☐ HSA: Yes ☐ No ☐

HRA/HSA Vendor Name ___________________________________

I/we agree to participate in the wellness program: YES ☐

ESTIMATED FIRST MONTH'S PREMIUM (due with this agreement for *new* groups only)

Amount __________________________ Check Number ___________________

BROKER INFORMATION

Broker Agency: ____

Individual Broker Contacts: ____________________________________ ____

Authorization Level:

☐ Broker of Record – has access to employer's membership and billing records and is able to speak with BCBSVT on employer's behalf.

☐ Broker of record and authorized contact – has broker of record access, is authorized to the same level as employer's group benefits manager and is able to submit enrollment change requests on employer's behalf.

SIGNATURE

Authorized Signatory (required) ____________________________________ Date ___________

Name (Print) ____ Title ____________________