



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:
<p>\$30/\$50 OV \$850/\$1,700 deductible 30% coinsurance</p>	<p>\$30/\$50 OV \$3,000/\$6,000 deductible then copays</p>	<p>\$2,750/\$5,500 deductible 0% coinsurance</p>	<p>\$6,550/\$13,100 deductible 0% coinsurance</p>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



**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 _____