BlueCross BlueShield of Vermont

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

Blue Edge Business

Individual Enrollment and Change Form

BRS

Please provide all information and print in ink or type.

Requested effective date _______ / _______ / _______

Section 1: EMPLOYER/EMPLOYEE INFORMATION

Employer Name (Required):		**Plan Selection:** ☐ Copay 1: $30/$50 OV, $850/$1,700 DEDUCTIBLE, 30% COINSURANCE ☐ Copay 2: $30/$50 OV, $3,000/$6,000 DEDUCTIBLE THEN COPAYS ☐ CDHP 1: $3,000/$6,000 DEDUCTIBLE, 0% COINSURANCE ☐ CDHP 2: $6,550/$13,100, 0% COINSURANCE	
Group Number/Division:	**Date of hire:**		
Last name:	**First name:**	**Social Security number****** (SSN):	
Mailing address:	**City:**	**State:**	**ZIP code:**
Phone number:	**Email address:**	**Primary Care Physician (PCP) name, or NPI number:** **Are you a current patient?** ☐ Yes ☐ No	
Date of birth (DOB): **Gender:** ☐ Male ☐ Female ☐ Unspecified	**Marital status:** ☐ Single ☐ Widowed ☐ Married/party to a civil union ☐ Domestic Partner**	**Employment status:** ☐ Active ☐ Retired ☐ Continuation	
Health coverage type: ☐ Employee only ☐ Employee/spouse (including party to a civil union/domestic partner) ☐ Employee/child ☐ Family			

Section 2: NEW ENROLLMENT (Check one, then go to SECTION 4)

☐ New group ☐ Open enrollment ☐ New hire/re-hire ☐ Continuation of coverage (COBRA/VIPER) ☐ Refusal ☐ Spouse turning age 65

☐ Transferred from another Blue Cross VT plan Transferring from certificate no. ____________________

Section 3: CHANGE/CANCELLATION

Change:

☐ Birth

☐ Adoption placement date ___/___/_____

☐ Marriage/Civil Union

☐ Divorce

Effective date ___/___/_____

☐ Address change

☐ Name change

☐ PCP change

☐ Court ordered change**

☐ Loss of coverage**

Cancel: **Date of cancellation** ___/___/_____

☐ **Voluntary cancel** (signature required)

____

Proof of other insurance is required to complete this request, if submitted outside of groups Open Enrollment period. Please include documentation when returning the form.

☐ **Left employment** (group benefits manager signature)

____

☐ **Other** (explain) ____________________

Section 4: LIST ALL DEPENDENTS BELOW TO BE ADDED OR REMOVED

Dependent Information **** Important note: Federal Law mandates our collection of SSN for all members over 45.			**Primary Care Physician (PCP) Information** (If Managed Care)
☐ Add ☐ Remove (Spouse/party to a civil union/domestic partner) Last Name First Name	SSN**** DOB	Gender ☐ Male ☐ Female	PCP Name NPI No.*** Are you a current patient? ☐ Yes ☐ No
☐ Add ☐ Remove Last Name First Name	SSN**** DOB	Gender ☐ Male ☐ Female	PCP Name NPI No.*** Are you a current patient? ☐ Yes ☐ No
☐ Add ☐ Remove Last Name First Name	SSN**** DOB	Gender ☐ Male ☐ Female	PCP Name NPI No.*** Are you a current patient? ☐ Yes ☐ No
☐ Add ☐ Remove Last Name First Name	SSN**** DOB	Gender ☐ Male ☐ Female	PCP Name NPI No.*** Are you a current patient? ☐ Yes ☐ No
☐ Add ☐ Remove Last Name First Name	SSN**** DOB	Gender ☐ Male ☐ Female	PCP Name NPI No.*** Are you a current patient? ☐ Yes ☐ No
☐ Add ☐ Remove Last Name First Name	SSN**** DOB	Gender ☐ Male ☐ Female	PCP Name NPI No.*** Are you a current patient? ☐ Yes ☐ No

Please see section 6 below for subscriber signature	
Group name:	**Employee name:**

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** ☐ 1-person ☐ 2-person ☐ Family			**Effective date**	**Type of coverage** ☐ 1-person ☐ 2-person ☐ 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 CERTIFICATE 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

If you are adding a dependent child, age 26 or older, contact customer service at (800) 247-2583 (TTY/TDD: 711) 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 age 45 and older (Federal mandate requires the collection of SSN)

Disclaimers

General Exclusions

A Medicare Supplement plan provides coverage designed to coordinate with your federal Medicare coverage. To fully understand a Medicare Supplement plan, you should read it alongside the Medicare Handbook, Medicare and You. We will provide Benefits as if you are enrolled in both Part A and Part B of Original Medicare and as if Medicare has paid its portion. You can find the Medicare and You handbook by visiting **Medicare.gov/Medicare-and-you**. Once you enroll, you will receive a Certificate of Coverage. Please read both carefully as they govern your specific benefits.

How We Protect Your Privacy

The law requires us to maintain the privacy of your health information by using or disclosing it only with your authorization or as otherwise allowed by law. You may find information about our privacy practices at **bluecrossvt.org/privacypolicies**.

NOTICE: Discrimination is Against the Law

BlueCross® and BlueShield® of Vermont (Blue Cross VT) and its affiliate The Vermont Health Plan (TVHP) comply with applicable federal and state civil rights laws and do not discriminate, exclude people or treat them differently on the basis of race, color, national origin, age, disability, gender identity or sex, ethnicity, sexual orientation, or HIV-status.

Blue Cross VT 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).

Blue Cross VT 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, contact **civilrightscoordinator@bcbsvt.com**

If you believe that Blue Cross VT has failed to provide these services or discriminated in another way based on race, color, national origin, age, disability, gender identity or sex, ethnicity, sexual orientation, or HIV-Status, you can file a grievance with: Civil Rights Coordinator, P.O. Box 186, Montpelier, VT 05601-0186, call (800) 247-2583 (TTY/TDD: 711), fax (802) 229-0511, or email **civilrightscoordinator@bcbsvt.com**. You can file a grievance in person, by mail, via fax, or by email. If you need help filing a grievance, the 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 or 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
200 Independence Avenue, SW Room 509F,
HHH Building Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at
https://www.hhs.gov/ocr/complaints/index.html

For free language-assistance services, call (800) 247-2583 (TTY/TDD: 711).

ARABIC

للحصول على خدمات المساعدة اللغوية المجانية ، اتصل (800) 247 2583 (TTY/TTD: 711). lilhusul ealaa khadmat almusaeadat allughawiat almajaaniat, atasal (800) 247-2583 (TTY/TDD: 711).

CHINESE

如需免费语言协助服务，请致电，(800) 247-2583 (TTY/TDD: 711). Rú xū miǎnfèi yǔyán xiézhù fúwù, qǐng zhìdiàn (800) 247-2583 TTY/TDD: 711).

CUSHITE (OROMO)

Tajaajila gargaarsa afaanii bilisaa argachuuf, (800) 247-2583 (TTY/TDD: 711) bilbili.

FRENCH

Pour des services d’assistance linguistique gratuits, appelez le (800) 247-2583 (TTY/TDD: 711).

GERMAN

Für kostenlose Sprachunterstützungsdienste rufen Sie (800) 247-2583 (TTY/TDD: 711) an.

ITALIAN

Per i servizi di assistenza linguistica gratuiti, chiamare il numero (800) 247-2583 (TTY/TDD: 711).

JAPANESE

無料の言語支援サービスについては，(800) 247-2583 (TTY/TDD: 711). Muryō no gengo shien sābisu ni tsuite wa, (800) 247-2583 (TTY/TDD: 711) made o denwa kudasai.

NEPALI

निःशुल्क भाषा-सहायता सेवाहरूको लागि, कल गर्नुहोस् , (800) 247-2583 (TTY/TDD: 711). Niḥśulka bhāṣā-sahāyatā sēvāharūkō lāgi, kala garnuhōs (800) 247-2583 (TTY/TDD: 711).

PORTUGUESE

Para serviços gratuitos de assistência linguística, ligue para (800) 247-2583 TTY/TDD: 711).

RUSSIAN

Чтобы получить бесплатную языковую помощь, позвоните по телефону (800) 247-2583 (TTY/TDD: 711).

SERBO-CROATIAN (SERBIAN)

За бесплатне услуге језичке помоћи позовите (800) 247-2583 (TTY/TTD: 711). Za besplatne usluge jezičke pomoći pozovite (800) 247-2583 (TTY/TDD: 711).

SPANISH

Para servicios gratuitos de asistencia lingüística, llame al (800) 247-2583 (TTY/TDD: 711).

TAGALOG

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa (800) 247-2583 (TTY/TDD: 711).

THAI

สำหรับบริการช่วยเหลือด้านภาษาฟรี โทร, (800) 247-2583 (TTY/TDD: 711). S̄ảh̄rạb brikār cĥwyh̄elụ̄x d̂ān p̣hās̄'ā frī thor (800) 247-2583 (TTY/TDD: 711).

UKRAINIAN

Щоб отримати безкоштовні мовні послуги, телефонуйте (800) 247-2583 (TTY/TDD: 711). Shchob otrymaty bezkoshtovni movni posluhy, telefonuyte (800) 247-2583 (TTY/TDD: 711)

VIETNAMESE

Đối với các dịch vụ hỗ trợ ngôn ngữ miễn phí, hãy gọi (800) 247-2583 (TTY/TDD: 711).