BlueCross BlueShield of Vermont

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

Submit one of three ways: email, fax, or mail.
See page 2 for more information.

Form E

VEHI

Enrollment and Change Form

Rev 10/11/2022

vehi

Please provide all information and print in ink or type.

Requested effective date 01/01/2025

Section 1: EMPLOYER/EMPLOYEE INFORMATION

Employer name: Lamoille North Supervisory Union		Employee Type: ☐ Licensed ☐ Non-Licensed ☐ ~~Confidential / Municipal~~ ☐ ~~Private School / Other~~	
Group /division #: (office use only) 316080204		Employment status: ☐ Active ☐ Continuation (COBRA)	
Health Plan Selection: ☐ Platinum ☐ Gold ☐ Gold CDHP ☐ Silver CDHP			
Health coverage type: ☐ Employee only ☐ Employee/spouse (including party to a civil union/domestic partner) ☐ Employee/child(ren) ☐ Family			
Health care spending account: ☐ Health Reimbursement Arrangement (HRA): all plans ☐ Health Savings Account (HSA): Silver CDHP only ☐ ~~None / Opt-out~~			
Last name:	First name:		Social Security number**** (SSN):
Mailing address:			PCP Name NPI No.*** Are you a current patient? ☐ Yes ☐ No ☐ resides outside of BCBSVT provider network (no PCP required)
City:	State:	ZIP code:	
Phone number:	Email address:		
Date of birth (DOB):	Gender: ☐ Male ☐ Female		Marital status: ☐ Single ☐ Married / party to a civil union ☐ Domestic Partner**

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

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

☐ Transferred from another BCBSVT plan Transferring from certificate no. ____________________

Section 3: CHANGE/CANCELLATION

Change: Effective date ___ ___ _____

☐ Birth
☐ Adoption placement date ___ ___ _____
☐ Marriage/Civil Union
☐ Divorce
☐ Address change
☐ Name change
☐ PCP change
☐ Court ordered change**
☐ Loss of coverage**

Cancel: Date of cancellation ___ ___ _____

☐ Voluntary cancel (signature required) ____________________
☐ Left employment (group benefits manager signature) ____________________
☐ Other (explain) ____________________

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

Dependent Information **** Important note: SSN required for all members.			Primary Care Provider (PCP) Information (required)
☐ 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 ☐ resides outside of BCBSVT provider network (no PCP required)
☐ Add ☐ Remove Last Name First Name	SSN**** DOB	Gender ☐ Male ☐ Female	PCP Name NPI No.*** Are you a current patient? ☐ Yes ☐ No ☐ resides outside of BCBSVT provider network (no PCP required)
☐ Add ☐ Remove Last Name First Name	SSN**** DOB	Gender ☐ Male ☐ Female	PCP Name NPI No.*** Are you a current patient? ☐ Yes ☐ No ☐ resides outside of BCBSVT provider network (no PCP required)
☐ Add ☐ Remove Last Name First Name	SSN**** DOB	Gender ☐ Male ☐ Female	PCP Name NPI No.*** Are you a current patient? ☐ Yes ☐ No ☐ resides outside of BCBSVT provider network (no PCP required)
☐ Add ☐ Remove Last Name First Name	SSN**** DOB	Gender ☐ Male ☐ Female	PCP Name NPI No.*** Are you a current patient? ☐ Yes ☐ No ☐ resides outside of BCBSVT provider network (no PCP required)

Please see section 6 on page 2 for employee signature

Employer 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 VEHI BENEFITS DESCRPITION AND OUTLINE OF COVERAGE.

SIGN HERE

▶ **Employee's signature** _____ **date** _____ ◀

Return this form to your Central Office for processing. Central Office can 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

NOTICE: Discrimination is Against the Law

Blue Cross and Blue Shield of Vermont (BCBSVT) complies with applicable federal and state civil rights laws and does not discriminate, exclude people or treat them differently on the basis of race, color, national origin, age, disability, gender identity or sex.

BCBSVT 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).

BCBSVT 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, please call (800) 247-2583. If you would like to file a grievance because you believe that BCBSVT has failed to provide services or discriminated on the basis of race, color, national origin, age, disability, gender identity or sex, contact:

Civil Rights Coordinator
Blue Cross and Blue Shield of Vermont
PO Box 186
Montpelier, VT 05601
(802) 371-3394
TDD/TTY: (800) 535-2227
civilrightscoordinator@bcbsvt.com

You can file a grievance by mail, or email at the contacts above. If you need assistance, our 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 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
Office for Civil Rights
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
(800) 368-1019
(800) 537-7697 (TDD)

For free language-assistance services, call (800) 247-2583.

ARABIC
للحصول على خدمات المساعدة اللغوية المجانية، اتصل على الرقم (800) 247-2583.

CHINESE
如需免費語言協助服務，請致電 (800) 247-2583 。

CUSHITE (OROMO)
Tajaajila gargaarsa afaan hiikuu kaffaltii malee argachuuf (800) 247-2583 bilbilaa.

FRENCH
Pour obtenir des services d'assistance linguistique gratuits, appelez le (800) 247-2583.

GERMAN
Kostenlose fremdsprachliche Unterstützung erhalten Sie unter (800) 247-2583.

ITALIAN
Per i servizi gratuiti di assistenza linguistica, chiamare il numero (800) 247-2583.

JAPANESE
無料の通訳サービスのご利用は、(800) 247-2583までお電話ください。

NEPALI
नि:शुल्क भाषा सहायता सेवाहरूका लागि, (800) 247-2583 मा कल गर्नुहोस्।

PORTUGUESE
Para serviços gratuitos de assistência linguística, ligue para o (800) 247-2583.

RUSSIAN
Чтобы получить бесплатные услуги переводчика, позвоните по телефону (800) 247-2583.

SERBO-CROATIAN (SERBIAN)
Za besplatnu uslugu prevođenja, pozovite na broj (800) 247-2583.

SPANISH
Para servicios gratuitos de asistencia con el idioma, llame al (800) 247-2583.

TAGALOG
Para sa libreng mga serbisyo ng tulong pangwika, tumawag sa (800) 247-2583.

THAI
สำหรับการให้บริการความช่วยเหลือด้านภาษาฟรี โทร (800) 247-2583

VIETNAMESE
Để biết các dịch vụ hỗ trợ ngôn ngữ miễn phí, hãy gọi số (800) 247-2583.

If you are adding a dependent child, age 26 or older, contact customer service at (800) 344-6690 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 for all members (Federal mandate requires the collection of SSN)

FORM F
Rev. 10/11/2022

School District ___LNMUUSD___CES___LNSU

Heath Reimbursement Arrangement (HRA)

Participant Enrollment Form

DataPath Administrative Services

Last Name _____ First Name _____ Middle Initial ____

Social Security Number _____ Date of Birth _____ Benefit Start Date 01/01/25

Address _____ City _____ State _____ Zip _____

Home or Cell Phone _____ Work Phone _____ Email _____

Professional/Licensed Staff (Primarily teachers and administration – principals/superintendents)

Health Plan	Single HRA	TP/PC/Fam HRA	Please write in tier level next to correct benefit
Platinum	$1,900	$4,000	
Gold	$1,900	$4,000	
Gold CDHP	$1,900	$4,000	
Silver CDHP	$1,900	$4,000	

Non-Licensed Staff (Non-licensed exempt and hourly)

Health Plan	Single HRA	TP/PC/Fam HRA	Please write in tier level next to correct benefit
Platinum	$2,200	$4,400	
Gold	$2,200	$4,400	
Gold CDHP	$2,200	$4,400	
Silver CDHP	$2,200	$4,400	

Tier level refers to:
S - single
2P - 2 person (adults)
PC - parent/ child(ren)
F - Family

***Please note a card will be ordered for the participant only; if additional cards are needed, please fill out the second page.**

Payment Information

Reimbursement will be made via Electronic Funds Transfer (direct deposit) into your checking or savings account.

Banking information Bank Name _____

Routing number _____ Account number _____

I hereby certify information provided herein to be correct and true and choose to participate.

Signature_____ Date_____

continued from page 1

Medicare Secondary Payor (MSP) Reporting Information (continued from reverse)

** **IMPORTANT: If your spouse or any of your dependents are covered by the health insurance plan listed on the reverse side please complete the form below for each person (besides yourself) who is covered by the plan.**

Dependent #1

Name _____ Gender ❑ Male ❑ Female

Social Security Number _____ Date of Birth _____

Relationship to You _____

Is this person a Medicare beneficiary? ☐ Yes ☐ No

If Yes, provide his/her Medicare HICN here _____

Dependent #2

Name _____ Gender ❑ Male ❑ Female

Social Security Number _____ Date of Birth _____

Relationship to You _____

Is this person a Medicare beneficiary? ☐ Yes ☐ No

If Yes, provide his/her Medicare HICN here _____

Dependent #3

Name _____ Gender ❑ Male ❑ Female

Social Security Number _____ Date of Birth _____

Relationship to You _____

Is this person a Medicare beneficiary? ☐ Yes ☐ No

If Yes, provide his/her Medicare HICN here _____

Dependent #4

Name _____ Gender ❑ Male ❑ Female

Social Security Number _____ Date of Birth _____

Relationship to You _____

Is this person a Medicare beneficiary? ☐ Yes ☐ No

If Yes, provide his/her Medicare HICN here _____

Lorem ipsum

If you have more than four dependents covered by this health insurance plan, please provide the above information about each person on a separate sheet of paper and attach to this form.

DataPath Administrative Services, Inc. 1601 Westpark Drive, Ste 9 Little Rock, AR 72204
Phone 866-207-3028 Fax 855-504-3457 | VTsupport@datapathadmin.com | www.datapathadmin.com/Vermont

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