

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



Please provide all information
and print in ink or type.

Requested effective date
01/01/2026

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:	
Mailing address:		Social Security number**** (SSN):	
City:		State:	
Phone number:		ZIP code:	
Date of birth (DOB):		Gender: ☐ Male ☐ Female	
		Marital status: ☐ Single ☐ Married / party to a civil union ☐ Domestic Partner**	
		PCP Name NPI No.***	
		Are you a current patient? ☐ Yes ☐ No	
		☐ resides outside of BCBSVT provider network (no PCP required)	

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:		Cancel:	
Effective date _____		Date of cancellation _____	
☐ Birth	☐ Address change	☐ Voluntary cancel (signature required) _____	
☐ Adoption placement date _____	☐ Name change	☐ Left employment (group benefits manager signature) _____	
☐ Marriage/Civil Union	☐ PCP change	☐ Other (explain) _____	
☐ Divorce	☐ Court ordered change**		
	☐ Loss of coverage**		

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)	SSN****	Gender	PCP Name	NPI No.***
Last Name First Name	DOB	☐ Male ☐ Female	Are you a current patient? ☐ Yes ☐ No	
			☐ resides outside of BCBSVT provider network (no PCP required)	
☐ Add ☐ Remove	SSN****	Gender	PCP Name	NPI No.***
Last Name First Name	DOB	☐ Male ☐ Female	Are you a current patient? ☐ Yes ☐ No	
			☐ resides outside of BCBSVT provider network (no PCP required)	
☐ Add ☐ Remove	SSN****	Gender	PCP Name	NPI No.***
Last Name First Name	DOB	☐ Male ☐ Female	Are you a current patient? ☐ Yes ☐ No	
			☐ resides outside of BCBSVT provider network (no PCP required)	
☐ Add ☐ Remove	SSN****	Gender	PCP Name	NPI No.***
Last Name First Name	DOB	☐ Male ☐ Female	Are you a current patient? ☐ Yes ☐ No	
			☐ resides outside of BCBSVT provider network (no PCP required)	
☐ Add ☐ Remove	SSN****	Gender	PCP Name	NPI No.***
Last Name First Name	DOB	☐ Male ☐ Female	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:
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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 DESCRIPTION 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
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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

निःशुल्क 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

สำหรับการให้บริการ
ความช่วยเหลือด้านภาษา
ฟรี 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. 09/02/2025

School District LNMUUSD CES LNSU
Health Reimbursement Arrangement (HRA)
Participant Enrollment Form



Last Name _____ First Name _____ Middle Initial _____
Social Security Number _____ Date of Birth _____ Benefit Start Date 01/01/2026
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	

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

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	

*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 _____

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 #1Name _____ 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 #2Name _____ 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 #3Name _____ 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 #4Name _____ 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 _____

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.