

VEHI

Enrollment and Change Form

Please submit this form to your Central Office for processing.

Requested effective date ____/____/____
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Section 1: EMPLOYER/EMPLOYEE INFORMATION

Employer name:		Employee type: <input type="checkbox"/> Licensed <input type="checkbox"/> Non-licensed <input type="checkbox"/> Confidential/Municipal <input type="checkbox"/> Private School/Other	
Group/division #: <small>(office use only)</small>		Employment status: <input type="checkbox"/> Active <input type="checkbox"/> Continuation (COBRA)	
Health plan selection: <input type="checkbox"/> Platinum <input type="checkbox"/> Gold <input type="checkbox"/> Gold CDHP <input type="checkbox"/> Silver CDHP			
Health coverage type: <input type="checkbox"/> Employee only <input type="checkbox"/> Employee/spouse (including party to a civil union/domestic partner) <input type="checkbox"/> Employee/child(ren) <input type="checkbox"/> Family			
Health care spending account: <input type="checkbox"/> Health Reimbursement Arrangement (HRA): all plans <input type="checkbox"/> Health Savings Account (HSA): For Public Schools Silver CDHP Only <input type="checkbox"/> None/Opt-out			
Last name:		First name:	Social Security number ****(SSN):
Mailing address:		PCP name	NPI No.***
City:		State:	ZIP code:
Phone number:		Email address:	
Date of birth (DOB):		Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Marital status: <input type="checkbox"/> Single <input type="checkbox"/> Married/party to a civil union <input type="checkbox"/> Domestic Partner**

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

<input type="checkbox"/> Open enrollment	<input type="checkbox"/> New hire/re-hire	<input type="checkbox"/> Continuation of coverage (COBRA)	<input type="checkbox"/> Refusal	<input type="checkbox"/> Spouse turning age 65
<input type="checkbox"/> Transferred from another VEHI plan Transferring from member ID no.: _____				

Section 3: CHANGE/CANCELLATION

Change: <input type="checkbox"/> Birth <input type="checkbox"/> Adoption placement date ____/____/____ <input type="checkbox"/> Marriage/Civil Union <input type="checkbox"/> Divorce	Effective date ____/____/____ <input type="checkbox"/> Address change <input type="checkbox"/> Name change <input type="checkbox"/> PCP change <input type="checkbox"/> Court ordered change** <input type="checkbox"/> Loss of coverage**	Cancel: <input type="checkbox"/> 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. <input type="checkbox"/> Left employment (group benefits manager signature) _____ <input type="checkbox"/> Other (explain) _____
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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)
<input type="checkbox"/> Add <input type="checkbox"/> Remove (Spouse/party to a civil union/domestic partner) Last Name First Name SSN*** DOB	PCP Name NPI No.*** <input type="checkbox"/> Male <input type="checkbox"/> Female Are you a current patient? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> resides outside of BCBSVT provider network (no PCP required)
<input type="checkbox"/> Add <input type="checkbox"/> Remove Last Name First Name SSN*** DOB	PCP Name NPI No.*** <input type="checkbox"/> Male <input type="checkbox"/> Female Are you a current patient? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> resides outside of BCBSVT provider network (no PCP required)
<input type="checkbox"/> Add <input type="checkbox"/> Remove Last Name First Name SSN*** DOB	PCP Name NPI No.*** <input type="checkbox"/> Male <input type="checkbox"/> Female Are you a current patient? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> resides outside of BCBSVT provider network (no PCP required)
<input type="checkbox"/> Add <input type="checkbox"/> Remove Last Name First Name SSN*** DOB	PCP Name NPI No.*** <input type="checkbox"/> Male <input type="checkbox"/> Female Are you a current patient? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> resides outside of BCBSVT provider network (no PCP required)
<input type="checkbox"/> Add <input type="checkbox"/> Remove Last Name First Name SSN*** DOB	PCP Name NPI No.*** <input type="checkbox"/> Male <input type="checkbox"/> Female Are you a current patient? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> 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 **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 <input type="checkbox"/> 1-person <input type="checkbox"/> 2-person <input type="checkbox"/> Family		Effective date		Type of coverage <input type="checkbox"/> 1-person <input type="checkbox"/> 2-person <input type="checkbox"/> Family

Section 6: SUBSCRIBER INFORMATION

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 VT, 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 VT.

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** _____ ◀

FOR OFFICE USE ONLY

Email: asinbox@bcbsvt.com	Fax: (802) 371-3329	Mail: Blue Cross VT P.O. Box 186 Montpelier, VT 05601-0186
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If you are adding a dependent child, age 26 or older, contact customer service at (800) 344-6690 (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 bluecrossvt.org/find-doctor
- **** = SSN required for all members (Federal mandate requires the collection of SSN).