BlueCross BlueShield of Vermont
An Independent Licensee of the Blue Cross and Blue Shield Association.

Please submit this form to your Central Office for processing.

VEHI
Enrollment and Change Form
for Public School Employees

Please provide all information and print in ink or type.

Section 1: EMPLOYER/EMPLOYEE INFORMATION

Employer name: WCUUSD

Employee type: ☐ Licensed ☐ Confidential/Municipal X Non-licensed ☐ Superintendent

Group/division #: 3160 8 0 2 4 1 - ___ ___ ___ ___ (HR use only)

Employment status: ☐ Active ☐ Continuation (COBRA)

Health plan selection: ☐ Platinum w/ HRA ☐ Gold w/ HRA ☐ Gold CDHP w/ HRA ☐ Silver CDHP w/ HRA ☐ Silver CDHP w/ HSA

Health coverage type: ☐ Employee only ☐ Employee/spouse (including party to a civil union/domestic partner) ☐ Employee/child(ren) ☐ Family

Last name: **First name:** **Social Security number ****(SSN):**

Mailing address:

City: **State:** **ZIP code:**

Phone number: **Email address:**

PCP name
NPI No.*** ___ ___ ___ ___ ___ ___ ___ ___ ___ ___
Are you a current patient? ☐ Yes ☐ No
☐ resides outside of BCBSVT provider network (no PCP required)

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 VEHI plan Transferring from member ID no.: _____

Section 3: CHANGE/CANCELLATION

Change: Effective date ___/___/____

☐ Birth
☐ Adoption placement ___/___/____
☐ 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) _____

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.

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** ☐ **No**

MEDICAL				DENTAL			
Insurance company (name and address)				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 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

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).