

Group Benefit Managers (GBMs) enrolling new employees may submit this form online at www.bcbsvt.com/groupenrollment. GBA or employee may complete all other transactions using our interactive PDF at www.bcbsvt.com/groupenrollmentform. Type information in, print, sign and submit one of three ways, email: asinbox@bcbsvt.com, fax: 802-371-3329, or mail: BCBSVT PO. Box 186 Montpelier, VT 05601.

REQUESTED EFFECTIVE DATE

/ /

SECTION 1 - EMPLOYER/EMPLOYEE INFORMATION

APPLYING FOR <input type="checkbox"/> VHP <input type="checkbox"/> TVHP BLUECARE <input type="checkbox"/> VFP <input type="checkbox"/> J PLAN <input type="checkbox"/> COMP <input type="checkbox"/> COMP HSA BLUE <input type="checkbox"/> TVHP HSA BLUECARE <input type="checkbox"/>		EMPLOYER NAME	ACCOUNT NO. (eight to nine characters i.e. 12345000 or T12345650)	
SOCIAL SECURITY NO.	LAST NAME	FIRST NAME		
MAILING ADDRESS		CITY	STATE	
CONTACT NUMBER		E-MAIL ADDRESS	EMPLOYMENT STATUS <input type="checkbox"/> ACTIVE <input type="checkbox"/> RETIRED <input type="checkbox"/> CONTINUATION	
DATE HIRED/REHIRED/or BECAME FULL TIME	MARITAL STATUS <input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED/PARTY TO A CIVIL UNION <input type="checkbox"/> DOMESTIC PARTNER** <input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED	HEALTH COVERAGE TYPE (*Includes Party to a Civil Union or Domestic Partner) <input type="checkbox"/> EMPLOYEE ONLY <input type="checkbox"/> EMPLOYEE/SPOUSE* <input type="checkbox"/> EMPLOYEE/CHILD <input type="checkbox"/> EMPLOYEE/CHILDREN <input type="checkbox"/> FAMILY		

SECTION 2 - NEW ENROLLMENT (Check one, then go to SECTION 5)

NEW HIRE RE-HIRE MEDICOMP SUPPLEMENT** (Attach copy of Medicare Card) SPOUSE TURNING AGE 65 OPEN ENROLLMENT CONTINUATION OF COVERAGE (COBRA/VIPER)
 REFUSAL NEW GROUP TRANSFERRED FROM ANOTHER BCBSVT PLAN Transferring From Certificate No. _____

SECTION 3 - CHANGE (Check all that apply)

DATE OF EVENT _____ REASON FOR CHANGE EVENT BIRTH ADOPTION MARRIAGE/CIVIL UNION DIVORCE DEATH
 LOSS OF COVERAGE** ENTER/DISCHARGE FROM MILITARY COURT ORDERED CHANGE** ADD/REMOVE SPOUSE/PARTY TO CIVIL UNION OR DEPENDENT (List in SECTION 5)
 ADDRESS CHANGE NAME CHANGE PCP CHANGE OTHER (explain) _____

SECTION 4 - POLICY CANCELLATION - Signature Required

<input type="checkbox"/> VOLUNTARY CANCEL (Subscriber Signature)	<input type="checkbox"/> LEFT EMPLOYMENT (Group Benefits Manager Signature)	SIGN HERE BELOW: X
<input type="checkbox"/> CANCEL CONTINUATION COVERAGE (Subscriber or Group Benefits Manager)	<input type="checkbox"/> OTHER, explain _____ (Subscriber Signature)	

SECTION 5 - LIST ALL MEMBERS BELOW TO BE ADDED OR REMOVED

IMPORTANT NOTE: Federal Law mandates our collection of SSN.

If you are adding a dependent child, age 26 or older, contact Customer Service 1-800-247-2583 for further instructions.

MEMBER INFORMATION				PRIMARY CARE PHYSICIAN (PCP) INFORMATION (IF MANAGED CARE)	
<input type="checkbox"/> ADD <input type="checkbox"/> REMOVE - Subscriber LAST NAME FIRST NAME SSN**** DOB <input type="checkbox"/> Male <input type="checkbox"/> Female				PCP Name PCP or NPI No.*** Are you a current patient? <input type="checkbox"/> Yes <input type="checkbox"/> No	
<input type="checkbox"/> ADD <input type="checkbox"/> REMOVE - Spouse/Party to a Civil Union LAST NAME FIRST NAME SSN**** DOB <input type="checkbox"/> Male <input type="checkbox"/> Female				PCP Name PCP or NPI No.*** Are you a current patient? <input type="checkbox"/> Yes <input type="checkbox"/> No	
<input type="checkbox"/> ADD <input type="checkbox"/> REMOVE - Dependent Child <input type="checkbox"/> Incapacitated dependent 26/older LAST NAME FIRST NAME SSN DOB <input type="checkbox"/> Male <input type="checkbox"/> Female				PCP Name PCP or NPI No.*** Are you a current patient? <input type="checkbox"/> Yes <input type="checkbox"/> No	
<input type="checkbox"/> ADD <input type="checkbox"/> REMOVE - Dependent Child <input type="checkbox"/> Incapacitated dependent 26/older LAST NAME FIRST NAME SSN DOB <input type="checkbox"/> Male <input type="checkbox"/> Female				PCP Name PCP or NPI No.*** Are you a current patient? <input type="checkbox"/> Yes <input type="checkbox"/> No	
<input type="checkbox"/> ADD <input type="checkbox"/> REMOVE - Dependent Child <input type="checkbox"/> Incapacitated dependent 26/older LAST NAME FIRST NAME SSN DOB <input type="checkbox"/> Male <input type="checkbox"/> Female				PCP Name PCP or NPI No.*** Are you a current patient? <input type="checkbox"/> Yes <input type="checkbox"/> No	
<input type="checkbox"/> ADD <input type="checkbox"/> REMOVE - Dependent Child <input type="checkbox"/> Incapacitated dependent 26/older LAST NAME FIRST NAME SSN DOB <input type="checkbox"/> Male <input type="checkbox"/> Female				PCP Name PCP or NPI No.*** Are you a current patient? <input type="checkbox"/> Yes <input type="checkbox"/> No	

PLEASE SEE SECTION 8 ON PAGE 2 FOR SUBSCRIBER SIGNATURE

