

Group Benefit Administrators (GBA) enrolling new employees may submit this form online at [www.bcbsvt.com/groupenrollment](http://www.bcbsvt.com/groupenrollment). GBA or employee may complete all other transactions using our interactive PDF at [www.bcbsvt.com/groupenrollmentform](http://www.bcbsvt.com/groupenrollmentform). Type information in, print, sign and submit one of three ways, email: [asinbox@bcbsvt.com](mailto:asinbox@bcbsvt.com), fax: 802-371-3329, or mail: BCBSVT P.O. 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	ZIP CODE
HOME PHONE NO.	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		EMPLOYMENT STATUS <input type="checkbox"/> ACTIVE <input type="checkbox"/> RETIRED <input type="checkbox"/> CONTINUATION		
DATE HIRED/REHIRED/or BECAME FULL TIME	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  CONVERT TO CARVEOUT\* (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  MARRIAGE/CIVIL UNION  DIVORCE  DEATH  
 ADOPTION  LOSS OF COVERAGE\*\*  ENTER/DISCHARGE FROM MILITARY  COURT ORDERED CHANGE\*\*  STUDENT (Please fill out SECTION 6 also)  
 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:
<input type="checkbox"/> CANCEL CONTINUATION COVERAGE (Subscriber or Group Benefits Manager)	<input type="checkbox"/> OTHER, explain _____ (Subscriber Signature)	<u>  X  </u>

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

IMPORTANT NOTE: If member is 45 or older SSN is required (Federal mandate requires the collection of SSN) If member is 19 or older Section 6 is also required to be filled out.

MEMBER INFORMATION				PRIMARY CARE PHYSICIAN (PCP) INFORMATION (IF MANAGED CARE)	
<input type="checkbox"/> ADD <input type="checkbox"/> REMOVE - Subscriber	LAST NAME	FIRST NAME	SOCIAL SECURITY NO.****	Male <input type="checkbox"/> Female <input type="checkbox"/>	PCP Name
				DATE OF BIRTH	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	SOCIAL SECURITY NO.****	Male <input type="checkbox"/> Female <input type="checkbox"/>	PCP Name
				DATE OF BIRTH	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	LAST NAME	FIRST NAME	SOCIAL SECURITY NO.****	Male <input type="checkbox"/> Female <input type="checkbox"/>	PCP Name
				DATE OF BIRTH	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	LAST NAME	FIRST NAME	SOCIAL SECURITY NO.****	Male <input type="checkbox"/> Female <input type="checkbox"/>	PCP Name
				DATE OF BIRTH	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	LAST NAME	FIRST NAME	SOCIAL SECURITY NO.****	Male <input type="checkbox"/> Female <input type="checkbox"/>	PCP Name
				DATE OF BIRTH	PCP or NPI No.***
				/ /	Are you a current patient? <input type="checkbox"/> Yes <input type="checkbox"/> No

PLEASE SEE SECTION 9 ON PAGE 2 FOR SUBSCRIBER SIGNATURE

\* = Includes Party to a Civil Union or Domestic partner  
 \*\* = Additional Documentation Required

\*\*\* = Physician Assistants & Nurse Practitioners are not valid  
 \*\*\*\* = SSN required age 45 and older (Federal mandate requires the collection of SSN)

