

BLUECARE ACCESS ENROLLMENT/ CHANGE FORM

All Information Must Be
Provided, Please Print In
Ink or Type

Group Benefit Administrators (GBA) 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 P.O. Box 186 Montpelier, VT 05601.

REQUESTED EFFECTIVE DATE

/ /

SECTION 1 - EMPLOYER/EMPLOYEE INFORMATION

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	
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 CONVERT TO MEDICARE 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

- VOLUNTARY CANCEL (Subscriber Signature) LEFT EMPLOYMENT (Group Benefits Manager Signature)
 CANCEL CONTINUATION COVERAGE (Subscriber or Group Benefits Manager) OTHER, explain _____

SIGN HERE BELOW:

X

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	
<input type="checkbox"/> ADD <input type="checkbox"/> REMOVE - Subscriber (<input type="checkbox"/> Resides Outside BCA Area) LAST NAME FIRST NAME SSN*** DOB <input type="checkbox"/> Male <input type="checkbox"/> Female				PCP Name PCP Phone No. City ST 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 (<input type="checkbox"/> Resides Outside BCA Area) LAST NAME FIRST NAME SSN*** DOB <input type="checkbox"/> Male <input type="checkbox"/> Female				PCP Name PCP Phone No. City ST 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 (<input type="checkbox"/> Resides Outside BCA Area) LAST NAME FIRST NAME SSN DOB <input type="checkbox"/> Male <input type="checkbox"/> Female				PCP Name PCP Phone No. City ST 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 (<input type="checkbox"/> Resides Outside BCA Area) LAST NAME FIRST NAME SSN DOB <input type="checkbox"/> Male <input type="checkbox"/> Female				PCP Name PCP Phone No. City ST 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 (<input type="checkbox"/> Resides Outside BCA Area) LAST NAME FIRST NAME SSN DOB <input type="checkbox"/> Male <input type="checkbox"/> Female				PCP Name PCP Phone No. City ST 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 (<input type="checkbox"/> Resides Outside BCA Area) LAST NAME FIRST NAME SSN DOB <input type="checkbox"/> Male <input type="checkbox"/> Female				PCP Name PCP Phone No. City ST Are you a current patient? <input type="checkbox"/> Yes <input type="checkbox"/> No	

PLEASE SEE SECTION 8 ON PAGE 2 FOR SUBSCRIBER SIGNATURE

* = Includes Party to a Civil Union or Domestic partner

*** = SSN required age 45 and older (Federal mandate requires the collection of SSN)

** = Additional Documentation Required

SECTION 6 - OTHER INSURANCE INFORMATION

After 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)?

Yes (If yes, please complete the applicable section below) If No (Go to SECTION 8)

MEDICARE

NAME of MEDICARE SUBSCRIBER	SOCIAL SECURITY NO.	MEDICARE/HIC NO.	PART A EFFECTIVE DATE	PART B EFFECTIVE DATE
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HEALTH

DENTAL

HEALTH INSURANCE COMPANY NAME	DENTAL INSURANCE COMPANY NAME
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ADDRESS	ADDRESS
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POLICY HOLDER NAME	POLICY/CERTIFICATE NO.	POLICY HOLDER NAME	POLICY/CERTIFICATE NO.
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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
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SECTION 7 - SUBSCRIBER SIGNATURE

I certify that the statements on this application and all information furnished by me are 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 CERTIFICATE AND OUTLINE OF COVERAGE.

SIGN HERE

▶ SUBSCRIBER'S SIGNATURE **X** _____ DATE _____ ◀

You can visit our website at www.bcbsvt.com