SMALL GROUP COVERAGE

Employee enrollment and change form

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

Submit one of three ways: email, fax, or mail, see page 2.
Please provide all information and print in ink or type.

Requested effective date
01 / 01 / 2024

Section 1: EMPLOYEE INFORMATION

Employer Group name:
E. F. Wall and Associates, Inc.

Group Number/Division:

Vermont Preferred Plans:
☐ Vermont Preferred Gold ☐ Vermont Preferred Silver Reflective
☐ Vermont Preferred Bronze

Vermont Select Plans:
☑ Vermont Select Gold CDHP ☐ Vermont Select Silver CDHP Reflective
☐ Vermont Select Bronze CDHP

Standard Plans:
☐ Platinum ☐ Gold ☐ Silver Reflective ☐ Bronze
☐ Bronze Integrated ☐ Silver CDHP Reflective ☐ Bronze CDHP

First name:	Last name:	Social Security Number (SSN)[1]:	Date of birth (DOB):
Physical address:	City:	State:	Zip code:
Mailing address:	City:	State:	Zip code:
Phone number:	Email address:	Gender: ☐ Male ☐ Female	
Primary Care Provider (Pcp) name, or NPI number[3] Are you a current patient? ☐ Yes ☐ No	Marital status: ☐ Single ☐ Domestic Partner[2] ☐ Married/party to a civil union	Employment status: ☐ Active ☐ Retired ☐ Continuation	

Health coverage type:
☐ Employee only ☐ Employee & spouse (including party to a civil union/domestic partner) ☐ Employee & Child or Children ☐ Family

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

☐ New group ☐ Open enrollment ☐ New hire/re-hire ☐ Continuation of coverage (COBRA/VIPER) ☐ Spouse turning age 65
☐ Special Enrollment Period (SEP) ***please indicate qualifying event in Section 3***
☐ Transferred from another Blue Cross VT plan, Member ID # _____

Section 3: CHANGE/CANCELLATION

CHANGE: (including SEP qualifying events)
Event date ___/___/____
☐ Pregnancy
☐ Birth
☐ Adoption placement date
___/___/____
☐ Marriage/Civil Union
☐ Divorce
☐ Address change
☐ Name change
☐ PCP change
☐ Court ordered change[2]
☐ Loss of coverage[2]

CANCEL:
Date of cancellation ___/___/____
☐ Voluntary cancel (subscriber signature required)
_____
☐ Left employment (group benefits administrator signature)
_____
Other (explain) _____

Please see section 6 on page 2 for subscriber signature

Section 4: LIST ALL DEPENDENTS BELOW TO BE ADDED OR REMOVED

Dependent Information Important note: federal law mandates our collection of SSN for all members.[1]			Primary Care Provider (PCP) Information[3]
☐ Add ☐ Remove Spouse/party to a civil union/domestic partner First name: Last name:	SSN[1] DOB	Gender ☐ Male ☐ Female	PCP Name: NPI No.[3] Are you a current patient? ☐ Yes ☐ No
☐ Add ☐ Remove Child or adult dependent with disability 26 & older[2] First name: Last name:	SSN[1] DOB	Gender ☐ Male ☐ Female	PCP Name: NPI No.[3] Are you a current patient? ☐ Yes ☐ No
☐ Add ☐ Remove Child or adult dependent with disability 26 & older[2] First name: Last name:	SSN[1] DOB	Gender ☐ Male ☐ Female	PCP Name: NPI No.[3] Are you a current patient? ☐ Yes ☐ No
☐ Add ☐ Remove Child or adult dependent with disability 26 & older[2] First name: Last name:	SSN[1] DOB	Gender ☐ Male ☐ Female	PCP Name: NPI No.[3] Are you a current patient? ☐ Yes ☐ No

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 (please complete the applicable section below) ☐ No

MEDICAL

Insurance company (name and address)		
Policyholder name	Policy certificate no.	Group no.
Effective date ___/___/____	Type of coverage ☐ 1-person ☐ 2-person ☐ Family	

DENTAL

Insurance company (name and address)		
Policyholder name	Policy certificate no.	Group no.
Effective date ___/___/____	Type of coverage ☐ 1-person ☐ 2-person ☐ Family	

Section 6: SUBSCRIBER SIGNATURE

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 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

▶ Employee signature ________________________________ Date ________________ ◀

If you are applying for coverage on behalf of another person other than your dependent, that person will need to complete an authorization form.

Submit one of three ways:

Email:	**Fax:**	**Mail:**
asinbox@bcbsvt.com	(802) 371-3329	Blue Cross and Blue Shield of Vermont P.O. Box 186 Montpelier, VT 05601-0186

If you are adding a dependent child, 26 or older, contact customer service at (800) 247-2583 for further instructions.

[1] SSN required all members (Federal mandate requires the collection of SSN)
[2] Additional documentation required
[3] See our "Find-a-Doctor" tool at **www.bluecrossvt.org/find-doctor**