BlueCross BlueShield of Vermont

An Independent Licensee of the Blue Cross and Blue Shield Association.

(800) 255-4550 | www.bluecrossvt.org

2024 PLAN SELECTION FORM

Employer and Employee use only.

Please provide all information and print in ink or type.

Requested Effective Date
/ /

Submit form to:

This form must be returned to:

_____
Group Benefit Administrator

by

_____
Date

Section 1: EMPLOYER/EMPLOYEE INFORMATION

Group name:	Member ID #:
First name:	Last name:

Section 2: PLAN SELECTION

Vermont Preferred Plans			Vermont Select Plans			Standard Plans						
Vermont Preferred Gold	Vermont Preferred Silver Reflective	Vermont Preferred Bronze	Vermont Select Gold CDHP	Vermont Select Silver CDHP Reflective	Vermont Select Bronze CDHP	Platinum	Gold	Silver Reflective	Bronze	Bronze Integrated	Silver CDHP Reflective	Bronze CDHP

Blue Cross Vermont plans offered by Employer

Employer Selection (may choose up to 13 plans)

☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

Employee selection (choose plan below)

☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

Aggregate Deductibles–
Full, single or entire family deductible must be satisfied before benefits are paid.

Stacked Deductibles–
Plan pays for an individual once the individual deductible is met (including family plans)

Aggregate Deductibles–
Full, single or entire family deductible must be satisfied before benefits are paid.

The following amount will be paid toward your premiums: ☐ Weekly ☐ Bi-weekly ☐ Monthly

$_____ Employee only

$_____ Employee & spouse

$_____ Employee & child or children

$_____ Family

Section 3: ACCEPT OR DECLINE ENROLLMENT

☐ I elect the plan above as my 2024 enrollment selection.

I understand that I can find the full Summary of Benefits and Coverage (SBC) at **www.bluecrossvt.org/smallbusiness**.

☐ I decline

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 60 days after you or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

If you or your dependent lose eligibility for a public benefit program, such as Dr. Dynasaur, you or your dependent may be eligible for coverage under this group health plan. In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 60 days after the loss of eligibility, marriage, birth, adoption, or placement for adoption.

Section 4: EMPLOYEE SIGNATURE

SIGN HERE

▶ Employee's signature _____ date _____ ◀

Note: This form is not a substitute as an application for new enrollment or membership changes. Please complete the small group coverage employee enrollment and change form.