INDIVIDUAL & FAMILY COVERAGE

Direct Enrollment & Change Form for Qualified Health Plans

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 3.

(800) 255-4550 (TTY/TDD: 711)
bluecrossvt.org/QHP

Please provide all information printed in ink or type.

Requested effective date
/ /

Section 1: INFORMATION

First Name:	Last Name:	Social Security Number[1] (SSN):	
Date of Birth (DOB):	Gender: ☐ Male ☐ Female	Marital Status: ☐ Single ☐ Married/party to a civil union ☐ Divorced ☐ Widowed	
Phone Number: Mobile Phone Number:	Email:	Primary Care Provider (PCP) Name, or NPI number[2]: Are you a current patient? ☐ Yes ☐ No	
Physical Address:	City:	State:	ZIP Code:
Mailing Address:	City:	State:	ZIP Code:

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

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

☐ Catastrophic *(must be under age 30 to apply)*

Membership type:
☐ Individual-only ☐ Individual + Spouse (including party to a civil union) ☐ Individual + Child(ren) ☐ Child only (under 18) ☐ Family

Section 2: NEW ENROLLMENT

☐ New Enrollment ☐ Open Enrollment ☐ Spouse Turning Age 65 ☐ Special Enrollment Period (SEP) ***please indicate qualifying event in Section 3***

☐ Transferred from another Blue Cross VT health plan, Member ID # _____

Please see section 8 on page 2 for Subscriber Signature

Section 3: CHANGE/CANCELLATION

CHANGE: (including SEP's)

Event date ___/___/____

☐ Pregnancy

☐ Birth

☐ Adoption Placement Date ___/___/____

☐ New Vermont Resident[4]
Date of Move ___/___/____

☐ Income Change

☐ Marriage

☐ Divorce/Dissolution of Civil Union

☐ Court Ordered Change[3]

☐ Loss of Coverage[3]

☐ ICHRA[3,5]

☐ QSEHRA[3,6]

Other changes:

☐ Name Change

☐ Address Change

CANCEL:
Date of Cancellation ___/___/____

☐ Voluntary Cancel (please sign Section 8)

☐ Other (explain)

____
____
____
____

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[2]
☐ Add ☐ Remove Spouse/party to a civil union First Name: Last Name:	SSN[1] DOB	Gender ☐ Male ☐ Female	PCP Name: NPI No.[2] Are you a current patient? ☐ Yes ☐ No
☐ Add ☐ Remove Child or adult dependent with disability 26 & older[3] First Name: Last Name:	SSN[1] DOB	Gender ☐ Male ☐ Female	PCP Name: NPI No.[2] Are you a current patient? ☐ Yes ☐ No
☐ Add ☐ Remove Child or adult dependent with disability 26 & older[3] First Name: Last Name:	SSN[1] DOB	Gender ☐ Male ☐ Female	PCP Name: NPI No.[2] Are you a current patient? ☐ Yes ☐ No
☐ Add ☐ Remove Child or adult dependent with disability 26 & older[3] First Name: Last Name:	SSN[1] DOB	Gender ☐ Male ☐ Female	PCP Name: NPI No.[2] Are you a current patient? ☐ Yes ☐ No
☐ Add ☐ Remove Child or adult dependent with disability 26 & older[3] First Name: Last Name:	SSN[1] DOB	Gender ☐ Male ☐ Female	PCP Name: NPI No.[2] Are you a current patient? ☐ Yes ☐ No
☐ Add ☐ Remove Child or adult dependent with disability 26 & older[3] First Name: Last Name:	SSN[1] DOB	Gender ☐ Male ☐ Female	PCP Name: NPI No.[2] Are you a current patient? ☐ Yes ☐ No

Section 5: OTHER INSURANCE INFORMATION

If you obtain health insurance coverage with Blue Cross VT, 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: AMERICAN INDIAN[4] OR ALASKA NATIVE FAMILY MEMBER(S)

Are you or anyone in your family an American Indian[7] with a federally recognized tribe or an Alaska Native? ☐ Yes (see Section 7) ☐ No

Please be aware, if you decide to direct enroll through us you will be ineligible to take advantage of any cost-sharing reduction (CSR) plans. If you would like to take advantage of a CSR plan offering, you will need to enroll through Vermont Health Connect.

[7] Please note that we are using this term rather than Native American because this is the term used in the federal law.

Section 7: ACKNOWLEDGEMENT OF INELIGIBLITY FOR SUBSIDIES

If you are not eligible for financial help (like federal tax credits, Vermont premium assistance, or cost-sharing reductions) or choose not to take advantage of the financial help through Vermont Health Connect, you can enroll directly with Blue Cross® and Blue Shield® of Vermont for coverage. This means you will be working directly with us for enrollment, getting bills, paying premiums and reporting changes to your membership.

If you are currently enrolled with Vermont Health Connect: By completing this enrollment form, you signify your desire to move your current enrollment from Vermont Health Connect to Blue Cross and Blue Shield of Vermont for coverage beginning the first of the month after receipt of your enrollment form. If your circumstances have changed, please use the Vermont Health Connects Plan Comparison tool at **VermontHealthConnect.gov** to determine if you are eligible for financial help before proceeding. Once you direct enroll with us, you cannot enroll through Vermont Health Connect unless you experience a qualifying life event or if you are found eligible for financial help. Please contact Vermont Health Connect at (855) 899-9600 for additional information.

By checking the box below, I confirm that I am the subscriber/policy holder in my household and authorized to make this decision. I understand that if I enroll directly with Blue Cross and Blue Shield of Vermont, I give up my right to subsidies through Vermont Health Connect.

If you are currently enrolled through Vermont Health Connect: I authorize Blue Cross and Blue Shield of Vermont to submit a cancellation to Vermont Health Connect on my behalf, since I am enrolling directly with Blue Cross and Blue Shield of Vermont.

▶ ☐ Yes, I understand.

Section 8: 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 acknowledge my ineligiblity for any subsidies. 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, OUTLINE OF COVERAGE and other elements of my contract.

SIGN HERE

▶ 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:
asinbox@bcbsvt.com

Fax:
(802) 371-3329

Mail: (please include the first month's premium)
Blue Cross and Blue Shield of Vermont
P.O. Box 186
Montpelier, VT 05601-0186

Please mail the first month's premium to Blue Cross and Blue Shield of Vermont.
We must receive payment before coverage can start.

If you are adding a dependent child age 26 or older, please contact customer service at (800) 247-2583 (TTY/TDD: 711) for further instructions.

[1] SSN required for all members (Federal mandate requires the collection of SSN)

[2] See our "Find-a-Doctor" tool at **bluecrossvt.org/find-doctor**

[3] Additional documentation required

[4] Must have at least 1 day of qualifying coverage 60 days prior to moving to Vermont

[5] ICHRA - Individual Coverage Health Reimbursement Arrangement

[6] QSEHRA - Qualified Small Employer Health Reimbursement Arrangment

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Non-discrimination Disclaimer Notice

bluecrossvt.org

DISCLAIMERS

General Exclusions

While your health plan covers a broad array of necessary services and supplies, it doesn't cover every possible medical expense. If you would like to review the list of general exclusions before enrolling, visit **bluecrossvt.org/contracts**, click on the plan in which you are enrolling and read the chapter entitled "General Exclusions." Once you enroll, you will receive an Outline of Coverage and a link to your Certificate of Coverage. Please read both carefully as they govern your specific benefits.

How We Protect Your Privacy

The law requires us to maintain the privacy of your health information by using or disclosing it only with your authorization or as otherwise allowed by law. You may find information about our privacy practices at **bluecrossvt.org/privacypolicies**.

NOTICE: Discrimination is Against the Law

Blue Cross® and Blue Shield® of Vermont (Blue Cross VT) and its affiliate The Vermont Health Plan (TVHP) comply with applicable federal and state civil rights laws and do not discriminate, exclude people or treat them differently on the basis of race, color, national origin, age, disability, gender identity or sex, ethnicity, sexual orientation, or HIV-status.

Blue Cross VT provides free aids and services to people with disabilities to communicate effectively with us. We provide, for example, qualified sign language interpreters and written information in other formats (e.g., large print, audio or accessible electronic format).

Blue Cross VT provides free language services to people whose primary language is not English. We provide, for example, qualified interpreters and information written in other languages.

If you need these services, contact **civilrightscoordinator@bcbsvt.com**.

If you believe that Blue Cross VT has failed to provide these services or discriminated in another way based on race, color, national origin, age, disability, gender identity or sex, ethnicity, sexual orientation, or HIV-Status, you can file a grievance with: Kienan D. Christianson, Civil Rights Coordinator, P.O. Box 186, Montpelier, VT 05601-0186, call (800) 247-2583 (TTY/TDD: 711), fax (802) 229-0511, or email **civilrightscoordinator@bcbsvt.com**. You can file a grievance in person, by mail, via fax, or by email. If you need help filing a grievance, Kienan D. Christianson, Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically or through the Office for Civil Rights Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW Room 509F,
HHH Building Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at
https://www.hhs.gov/ocr/complaints/index.html

For free language-assistance service, call (800) 247-2583 (TTY/TDD: 711).

ARABIC	للحصول على خدمات المساعدة اللغوية المجانية ، اتصل (800) 247 2583 (TTY/TDD: 711). lilhusul ealaa khadmat almusaeadat allughawiat almajaaniat, atasal (800) 247-2583 (TTY/TDD: 711).
CHINESE	如需免费语言协助服务，请致电，(800) 247-2583 (TTY/TDD: 711). Rú xū miǎnfèi yǔyán xiézhù fúwù, qǐng zhìdiàn (800) 247-2583 TTY/TDD: 711).
CUSHITE (OROMO)	Tajaajila gargaarsa afaanii bilisaa argachuuf, (800) 247-2583 (TTY/TDD: 711) bilbili.
FRENCH	Pour des services d’assistance linguistique gratuits, appelez le (800) 247-2583 (TTY/TDD: 711).
GERMAN	Für kostenlose Sprachunterstützungsdienste rufen Sie (800) 247-2583 (TTY/TDD: 711) an.

ITALIAN	Per i servizi di assistenza linguistica gratuiti, chiamare il numero (800) 247-2583 (TTY/TDD: 711).
JAPANESE	無料の言語支援サービスについては, (800) 247-2583 (TTY/TDD: 711). Muryō no gengo shien sābisu ni tsuite wa, (800) 247-2583 (TTY/TDD: 711) made o denwa kudasai.
NEPALI	निःशुल्क भाषा-सहायता सेवाहरूको लागि, कल गर्नुहोस् , (800) 247-2583 (TTY/TDD: 711). Niḥśulka bhāṣā-sahāyatā sēvāharūkō lāgi, kala garnuhōs (800) 247-2583 (TTY/TDD: 711).
PORTUGUESE	Para serviços gratuitos de assistência linguística, ligue para (800) 247-2583 (TTY/TDD: 711).
RUSSIAN	Чтобы получить бесплатную языковую помощь, позвоните по телефону (800) 247-2583 (TTY/TDD: 711).

SERBO-CROATIAN (SERBIAN)	За бесплатне услуге језичке помоћи позовите (800) 247-2583 (TTY/TDD: 711). Za besplatne usluge jezičke pomoći pozovite (800) 247-2583 (TTY/TDD: 711).
SPANISH	Para servicios gratuitos de asistencia lingüística, llame al (800) 247-2583 (TTY/TDD: 711).
TAGALOG	PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa (800) 247-2583 (TTY/TDD: 711).
THAI	สำหรับบริการช่วยเหลือด้านภาษาฟรี โทร,(800) 247-2583 (TTY/TDD: 711). S̄ả h̄rạb brikār ch̀wyh̄elū̱x d̂ān p̣hās̄'ā frī thor (800) 247-2583 (TTY/TDD: 711).

UKRAINIAN	Щоб отримати безкоштовні мовні послуги, телефонуйте (800) 247-2583 (TTY/TDD: 711). Shchob otrymaty bezkoshtovni movni posluhy, telefonuyte (800) 247-2583 (TTY/TDD: 711)
VIETNAMESE	Đối với các dịch vụ hỗ trợ ngôn ngữ miễn phí, hãy gọi (800) 247-2583 (TTY/TDD: 711).