BlueCross BlueShield of Vermont

An Independent Licensee of the Blue Cross and Blue Shield Association

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** (REQUIRED)		EMPLOYMENT STATUS ☐ ACTIVE ☐ RETIRED ☐ CONTINUATION	
DATE HIRED/REHIRED/or BECAME FULL TIME	MARITAL STATUS ☐ SINGLE ☐ MARRIED/PARTY TO A CIVIL UNION ☐ DOMESTIC PARTNER** ☐ DIVORCED ☐ WIDOWED		HEALTH COVERAGE TYPE (*Includes Party to a Civil Union or Domestic Partner) ☐ EMPLOYEE ONLY ☐ EMPLOYEE/SPOUSE* ☐ EMPLOYEE/CHILD ☐ EMPLOYEE/CHILDREN ☐ 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______________ (Subscriber Signature)

SIGN HERE BELOW:

X ______________________

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

IMPORTANT NOTE: Federal Law mandates our collection of Social Security Numbers (SSN).

If you are adding a dependent child, age 26 or older, contact Customer Service (800) 247-2583 for further instructions.

MEMBER INFORMATION				**PRIMARY CARE PHYSICIAN (PCP) INFORMATION**
☐ ADD ☐ REMOVE - Subscriber (☐ Resides Outside BCA Area)				**PCP Name** **PCP Phone No.**
LAST NAME	FIRST NAME	SSN*** / DOB	☐ Male ☐ Female	City ST / **Are you a current patient?** ☐ Yes ☐ No
☐ ADD ☐ REMOVE - Spouse/Party to a Civil Union (☐ Resides Outside BCA Area)				**PCP Name** **PCP Phone No.**
LAST NAME	FIRST NAME	SSN*** / DOB	☐ Male ☐ Female	City ST / **Are you a current patient?** ☐ Yes ☐ No
☐ ADD ☐ REMOVE - Dependent Child ☐ Incapacitated dependent 26/older (☐ Resides Outside BCA Area)				**PCP Name** **PCP Phone No.**
LAST NAME	FIRST NAME	SSN / DOB	☐ Male ☐ Female	City ST / **Are you a current patient?** ☐ Yes ☐ No
☐ ADD ☐ REMOVE - Dependent Child ☐ Incapacitated dependent 26/older (☐ Resides Outside BCA Area)				**PCP Name** **PCP Phone No.**
LAST NAME	FIRST NAME	SSN / DOB	☐ Male ☐ Female	City ST / **Are you a current patient?** ☐ Yes ☐ No
☐ ADD ☐ REMOVE - Dependent Child ☐ Incapacitated dependent 26/older (☐ Resides Outside BCA Area)				**PCP Name** **PCP Phone No.**
LAST NAME	FIRST NAME	SSN / DOB	☐ Male ☐ Female	City ST / **Are you a current patient?** ☐ Yes ☐ No
☐ ADD ☐ REMOVE - Dependent Child ☐ Incapacitated dependent 26/older (☐ Resides Outside BCA Area)				**PCP Name** **PCP Phone No.**
LAST NAME	FIRST NAME	SSN / DOB	☐ Male ☐ Female	City ST / **Are you a current patient?** ☐ Yes ☐ No

PLEASE SEE SECTION 7 ON PAGE 2 FOR SUBSCRIBER SIGNATURE

* = Includes Party to a Civil Union or Domestic partner
** = Additional Documentation Required
*** = SSN required age 45 and older (Federal mandate requires the collection of SSN)

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

HEALTH

HEALTH INSURANCE COMPANY NAME	
ADDRESS	
POLICY HOLDER NAME	POLICY/CERTIFICATE NO.
EFFECTIVE DATE / /	TYPE OF COVERAGE ☐ 1 PERSON ☐ 2 PERSON ☐ FAMILY

DENTAL

DENTAL INSURANCE COMPANY NAME	
ADDRESS	
POLICY HOLDER NAME	POLICY/CERTIFICATE NO.
EFFECTIVE DATE / /	TYPE OF COVERAGE ☐ 1 PERSON ☐ 2 PERSON ☐ FAMILY

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 _____

NOTICE: Discrimination is Against the Law

Blue Cross and Blue Shield of Vermont (BCBSVT) 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.

BCBSVT 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).

BCBSVT 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, please call (800) 247-2583. If you would like to file a grievance because you believe that BCBSVT has failed to provide services or discriminated on the basis of race, color, national origin, age, disability, gender identity or sex, contact:

Civil Rights Coordinator
Blue Cross and Blue Shield of Vermont
PO Box 186
Montpelier, VT 05601
(802) 371-3394

TDD/TTY: (800) 535-2227
civilrightscoordinator@bcbsvt.com

You can file a grievance by mail, or email at the contacts above. If you need assistance, our 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 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
(800) 368-1019
(800) 537-7697 (TDD)

Complaint forms are available at www.hhs.gov/ocr/office/file/index.html.

For free language-assistance services, call (800) 247-2583.

ARABIC

للحصول على خدمات المساعدة اللغوية المجانية، اتصل على الرقم (800) 247-2583.

CHINESE

如需免費語言協助服務，請致電(800) 247-2583。

CUSHITE (OROMO)

Tajaajila gargaarsa afaan hiikuu kaffaltii malee argachuuf (800) 247-2583 bilbilaa.

FRENCH

Pour obtenir des services d'assistance linguistique gratuits, appelez le (800) 247-2583.

GERMAN

Kostenlose fremdsprachliche Unterstützung erhalten Sie unter (800) 247-2583.

ITALIAN

Per i servizi gratuiti di assistenza linguistica, chiamare il numero (800) 247-2583.

JAPANESE

無料の通訳サービスのご利用は、(800) 247-2583までお電話ください。

NEPALI

निःशुल्क भाषा सहायता सेवाहरूका लागि, (800) 247-2583 मा कल गर्नुहोस्।

PORTUGUESE

Para serviços gratuitos de assistência linguística, ligue para o (800) 247-2583.

RUSSIAN

Чтобы получить бесплатные услуги переводчика, позвоните по телефону (800) 247-2583.

SERBO-CROATIAN (SERBIAN)

Za besplatnu uslugu prevođenja, pozovite na broj (800) 247-2583.

SPANISH

Para servicios gratuitos de asistencia con el idioma, llame al (800) 247-2583.

TAGALOG

Para sa libreng mga serbisyo ng tulong pangwika, tumawag sa (800) 247-2583.

THAI

สำหรับการให้บริการความช่วยเหลือด้านภาษาฟรี โทร (800) 247-2583

VIETNAMESE

Để biết các dịch vụ hỗ trợ ngôn ngữ miễn phí, hãy gọi số (800) 247-2583.

You can visit our website at www.bcbsvt.com