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 for more information.

Individual direct-enrollment and change form

Please provide all information and print in ink or type.

Requested effective date / /

Section 1: INFORMATION

Last name:	First name, middle initial:	Social Security number[1] (SSN):	
Physical address:	City:	State:	ZIP code:
Mailing address:	City:	State:	ZIP code:
Date of birth (DOB):	Sex: ☐ Male ☐ Female	Marital status: ☐ Single ☐ Married/party to a civil union	
Phone number: Cell phone (optional):	Email address:	Primary Care Provider (PCP) name, or NPI number: Are you a current patient? ☐ Yes ☐ No	

Plan Selection: ☐ Platinum ☐ Gold ☐ Silver Reflective ☐ Bronze ☐ BRONZE *without Rx MOOP* ☐ Silver CDHP *(Consumer-Directed Health Plan)* Reflective ☐ Bronze CDHP ☐ Blue Rewards Gold ☐ Blue Rewards Silver Reflective ☐ Blue Rewards Bronze ☐ Blue Rewards Gold CDHP ☐ Blue Rewards Silver CDHP Reflective ☐ Blue Rewards Bronze CDHP ☐ Blue Rewards Catastrophic *(eligibility requirements 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 ☐ Transferred from another BCBSVT plan

☐ Special Enrollment Period (SEP) *please indicate qualifying event in Section 3* *Transferring from ID number* ______________________________

Section 3: CHANGE/CANCELLATION

Change: *(including SEP qualifying events)* ***Effective date*** ___/___/_____

☐ *Pregnancy*
☐ Birth
☐ Adoption
placement date ___/___/_____
☐ Income change

☐ Marriage
☐ Divorce/dissolution of Civil Union
☐ Court ordered change[2]
☐ Loss of coverage[2]

other changes:
☐ Name change
☐ New Vermont resident
date of move ___/___/_____
☐ 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[3]

Dependent	SSN / DOB	Sex	PCP
☐ Add ☐ Remove *(Spouse/party to a civil union/domestic partner)* Last Name First Name	SSN[1] DOB	Sex ☐ Male ☐ Female	PCP Name NPI No.[3] Are you a current patient? ☐ Yes ☐ No
☐ Add ☐ Remove ☐ Incapacitated dependent 26/older[2] Last Name First Name	SSN[1] DOB	Sex ☐ Male ☐ Female	PCP Name NPI No.[3] Are you a current patient? ☐ Yes ☐ No
☐ Add ☐ Remove ☐ Incapacitated dependent 26/older[2] Last Name First Name	SSN[1] DOB	Sex ☐ Male ☐ Female	PCP Name NPI No.[3] Are you a current patient? ☐ Yes ☐ No
☐ Add ☐ Remove ☐ Incapacitated dependent 26/older[2] Last Name First Name	SSN[1] DOB	Sex ☐ Male ☐ Female	PCP Name NPI No.[3] Are you a current patient? ☐ Yes ☐ No
☐ Add ☐ Remove ☐ Incapacitated dependent 26/older[2] Last Name First Name	SSN[1] DOB	Sex ☐ Male ☐ Female	PCP Name NPI No.[3] Are you a current patient? ☐ Yes ☐ No
☐ Add ☐ Remove ☐ Incapacitated dependent 26/older[2] Last Name First Name	SSN[1] DOB	Sex ☐ Male ☐ Female	PCP Name NPI No.[3] Are you a current patient? ☐ Yes ☐ No

Please see section 8 on page 2 for subscriber signature

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)			**DENTAL**	Insurance company (name and address)		
	Policyholder name	Policy certificate no.	Group no.		Policyholder name	Policy certificate no.	Group no.
	Effective date	Type of coverage ☐ 1-person ☐ 2-person ☐ Family			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[4] 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 (VHC).

[4] 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 subsidies (like Federal premium assistance, premium tax credits, reduced cost-sharing plans or Vermont premium assistance) or choose not to take advantage of them, you can enroll directly with Blue Cross and Blue Shield of Vermont for coverage beginning 2020. This means that, for 2020 coverage, you will be working directly with us for enrollment, getting bills, paying premiums and reporting changes to your membership.

By completing this form, you signify your desire to move your current enrollment from Vermont Health Connect to BCBSVT for coverage beginning January 1, 2020. If your circumstances have changed since last year, please use the Vermont Health Connect plan comparison tool (**https://vt.checkbookhealth.org)** to be sure you're not newly eligible for premium assistance before proceeding. Once you direct enroll with us, you cannot enroll through Vermont Health Connect unless you experience a Special Enrollment Period (SEP) qualifying life event.

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 BCBSVT, I give up my right to subsidies. I authorize BCBSVT to submit a cancellation to Vermont Health Connect on my behalf for 2020 coverage, since I am enrolling directly with BCBSVT.

▶ ☐ 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 Blue Shield of Vermont P.O. Box 186 Montpelier, VT 05601-0186
Please mail the first month's premium to BCBSVT. 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 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.bcbsvt.com/findadoctor**

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

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
Office for Civil Rights
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
(800) 368-1019
(800) 537-7697 (TDD)

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.

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