

INDIVIDUAL & FAMILY COVERAGE

Direct-Enrollment & change form



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

Submit one of three ways: email, fax, or mail, see page 3.
Please provide all information and print in ink or type.

Requested effective date

/ /

Section 1: INFORMATION

Last name:	First name:	Social Security number ¹ (SSN):	
Date of birth (DOB):	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Marital status: <input type="checkbox"/> Single <input type="checkbox"/> Married/party to a civil union	
Phone number: Cell phone (optional):	Email address:	Primary Care Provider (Pcp) name, or npi number ³ : Are you a current patient? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Physical address:	City:	State:	ZIP code:
Mailing address:	City:	State:	ZIP code:

Standard Plans:

Platinum Gold Silver Reflective Bronze Bronze without Rx MOOP Silver CDHP Bronze CDHP

Vermont Preferred Plans:

Vermont Preferred Gold Vermont Preferred Silver Reflective Vermont Preferred Bronze

Vermont Select Plans:

Vermont Select CDHP Gold Vermont Select CDHP Silver Reflective Vermont Select CDHP Bronze

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 BCBSVT plan Transferring from ID number _____

Please see section 8 on page 2 for subscriber signature

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 change²

Loss of coverage²

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) Information³

Add Remove

Spouse/party to a civil union

SSN¹

DOB

Sex

Male

Female

Last name: _____ First name: _____

PCP Name:

NPI No.³

Are you a current patient? Yes No

Add Remove

Child or incapacitated dependent 26 & older²

SSN¹

DOB

Sex

Male

Female

Last name: _____ First name: _____

PCP Name:

NPI No.³

Are you a current patient? Yes No

Add Remove

Child or incapacitated dependent 26 & older²

SSN¹

DOB

Sex

Male

Female

Last name: _____ First name: _____

PCP Name:

NPI No.³

Are you a current patient? Yes No

Add Remove

Child or incapacitated dependent 26 & older²

SSN¹

DOB

Sex

Male

Female

Last name: _____ First name: _____

PCP Name:

NPI No.³

Are you a current patient? Yes No

Add Remove

Child or incapacitated dependent 26 & older²

SSN¹

DOB

Sex

Male

Female

Last name: _____ First name: _____

PCP Name:

NPI No.³

Are you a current patient? Yes No

Add Remove

Child or incapacitated dependent 26 & older²

SSN¹

DOB

Sex

Male

Female

Last name: _____ First name: _____

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)			DENTAL	Insurance company (name and address)		
	Policyholder name	Policy certificate no.	Group no.		Policyholder name	Policy certificate no.	Group no.
	Effective date <u> </u> / <u> </u> / <u> </u>	Type of coverage <input type="checkbox"/> 1-person <input type="checkbox"/> 2-person <input type="checkbox"/> Family			Effective date <u> </u> / <u> </u> / <u> </u>	Type of coverage <input type="checkbox"/> 1-person <input type="checkbox"/> 2-person <input type="checkbox"/> Family	

Section 6: AMERICAN INDIAN⁴ OR ALASKA NATIVE FAMILY MEMBER(S)

Are you or anyone in your family an American Indian⁴ 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).

⁴Please 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 INELIGIBILITY 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 2021. This means that, for 2021 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, 2021. 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 2021 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 ineligibility 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/find-a-doctor

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