VACE / BCBSVT PLAN ENROLLMENT & CHANGE FORM

Please return completed enrollment forms to

VACE INSURANCE PROGRAM (Provided by Chamber Benefits Inc.)
P.O. BOX 810
MONTPELIER, VT 05601

Phone: 802-229-2231 Fax: 802-223-4257
E-mail: vacehealth@vtchamber.com

PLEASE PRINT CLEARLY

Social Security No: - -

Employer Name:

Name:
(First, MI, Last)

EMPLOYEE Email (for BCBSVT / VACE use only)

Home Address:

Select BCBSVT Insurance Type, if coverage desired:
(please check one only - verify with your employer options available to you)

( ) 1,500 PPO ( ) 2,500 PPO ( ) 3,000 PPO
( ) 4,000 PPO ( ) 2,000 CDHP ( ) 2,450 CDHP
( ) 5,950 CDHP

City, State, Zip:

Date of Birth : Gender: (M) (F)

Health Plan Coverage Desired: (please check one only)

( ) Single (employee only)
( ) Two Person (employee + 1 dependent)
( ) Family (employee + 2 or more dependents)
( ) Medicare Supplement (employee only)
( ) I Refuse Coverage (please refer to signature box)

Marital Status: (please check one only)

( ) Single ( ) Legally Separated
( ) Married ( ) Widowed
( ) Divorced ( ) Civil Union
( ) Domestic Partner

Employer Completes This Section

VACE ID # ________ **BCBSVT GROUP #** 32128

EMPLOYER PROBATION PERIOD: ______DAYS NEW HIRES
______DAYS REHIRES

ADDITION
( ) New Hire
( ) Rehire
( ) Open Enrollment
( ) Cobra
( ) Full-time Status
( ) Other (explain below)

CANCELLATION
( ) Left Employment
( ) Other Insurance
( ) Voluntary
( ) Cobra Ending
( ) Other (explain below)

CHANGES *- check boxes that apply*

( ) Address Change ( ) Name Change
( ) Convert to VACE / BCBSVT Medicare Supplement

ADD DEPENDENT
( ) Birth
( ) Marriage/Civil Union/Domestic Part.
( ) Adoption
( ) Other (explain on line below)

DELETE DEPENDENT
( ) Divorce
( ) Legal Separation
( ) Change in Student Status
( ) Other (explain on line below)

DATE OF HIRE / REHIRE	DATE OF EVENT	**EFFECTIVE DATE**

COMPLETE THE FOLLOWING SECTION FOR ALL PERSONS COVERED -
If totally disabled prior to age 19, attach proof of disability for eligibility review.

Relationship	Add	Delete	Name (Include last name, if different)	Sex M	Sex F	Social Security No.	Date of Birth mo/day/yr	√ If Resides with Employee	√ If Step-Child	√ If Full Time Student 19-25?
Self										
Spouse										
Civil Union Partner										
Domestic Partner										
Child										
Child										
Child			add additional on separate paper							

OTHER HEALTH CARE COVERAGE: Do you or your dependents have other health insurance under a group plan, HMO, or Medicare that is not being replaced by this plan? ( ) No ( ) Yes If YES, please provide the following:

NAME OF PERSON COVERED SOC. SEC. NO. EMPLOYER INSURANCE CO. NAME

Signature Box

I hereby request enrollment of myself and eligible family dependents and authorize my employer to deduct from my wages or salary the amount of contributions, if any, for the coverage requested. I understand that the coverage provided will be subject to the terms and conditions of the group insurance policy. I authorize any licensed physicians, hospital, clinic, pharmacist, employer, and all other agencies or organizations to permit BCBSVT to see, or to get a copy of, all medical records, prescribed drug, employment and insurance coverage records which pertain to me or my enrolled dependents. The information above is true and correct to the best of my knowledge and I understand that my benefits may be affected by failure to provide complete, accurate and timely information.

( ) I accept medical coverage.
( ) I decline medical coverage and understand I must wait for the next open enrollment period if I desire coverage in the future.

Employee please sign here **Date**

See Special Enrollment Notice on Reverse

Special Enrollment Notice

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 "30 days" after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage). 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 "30 days" after the marriage, birth, adoption, or placement for adoption. To request special enrollment or obtain more information, contact VACE Insurance at 802-229-2231 or VACEHealth@VTChamber.com