

VADA

Instructions for Completing the Group Enrollment/Change Form

Please be sure to complete each section and print clearly. Applications will be RETURNED UNPROCESSED if information is missing. If you have questions about this form, please call your Group Benefits Manager.

SECTION 1: EMPLOYER/EMPLOYEE INFORMATION

Fill in all boxes except the Effective Date. The Group Benefits Manager and VADA will determine your effective date. Your Group Benefits Manager can provide you with the waiting period.

SECTION 2: NEW ENROLLMENT

Check the box that indicates your reason for enrolling then skip to section 4.

SECTION 3: CHANGE

Check the box that indicates your reason for changing your coverage. Fill in the date of the event necessitating the change. Additional documentation is required when the change is:

- Court-ordered (provide a copy of the court decree)
- Loss of Coverage (provide copy of Certificate of Coverage)

SECTION 4: MEMBERSHIP INFORMATION

List all eligible dependents to be covered by your health and/or dental care coverage, including yourself. Additional dependents may be listed on a separate page. Documentation is required for incapacitated dependents.

SECTION 5: LIFE INSURANCE BENEFITS

MANDATORY for all benefit eligible employees. Indicate which life policy you are applying for and fill in the primary and secondary beneficiaries.

SECTION 6: HEALTH INSURANCE BENEFITS

Indicate which Health Plan Option, BCBSVT Group Number and Health Plan Type. If you select "Refusal" please read the following: You and your dependents may refuse coverage under the plan. However, if any individual refuses coverage, he or she will not be able to later enroll in the plan until the anniversary month (November). The only exception to this rule applies when an employee or dependent refuses coverage because he or she has other health coverage at the time enrollment is offered and loses that health coverage for one of the following reasons:

1. The other health coverage was under COBRA/VIPER and the continuation coverage period has expired; or
2. The other health coverage was not under COBRA/VIPER and the individual lost health coverage because he or she was no longer eligible for that coverage (through loss of employment, divorce, legal separation, death, reduction in hours, etc.) or the employer ceased making contributions for such health coverage.

If an individual refuses coverage for one of the above reasons, he or she may enroll upon termination of that coverage. If the individual who refused coverage is not an employee, the employee through whom that individual is eligible for coverage may also enroll at that time.

You will be required to provide proof that you had other health insurance coverage at the time you refused enrollment and proof of the reason why that health insurance coverage terminated.

SECTION 7: DENTAL INSURANCE BENEFITS

If applicable, indicate which Dental Plan Option, NEDD Group Number and Dental Plan Type.

SECTION 8: SHORT-TERM DISABILITY INCOME BENEFITS

If applicable, indicate benefit type and list weekly earnings.

SECTION 9: OTHER INSURANCE

If you or any of your dependents are covered by another health or dental plan, complete this section. Be sure to include information about Medicare, Medicaid or dental insurance.

SECTION 10: SIGNATURES

The employee and Group Benefits Manager *must* sign and date all enrollment/change forms.



Group Enrollment/Change Form

INSURED'S LAST NAME

SECTION 1: EMPLOYER/EMPLOYEE INFORMATION

EMPLOYER NAME:		WAITING PERIOD:		DAYS	
SOCIAL SECURITY NO:	LAST NAME:	FIRST NAME:			
MAILING ADDRESS:		CITY:	STATE:	ZIP CODE:	
DATE OF HIRE/REHIRE/OR BECAME FULL TIME:	EFFECTIVE DATE: (VADA USE ONLY)	MARITAL STATUS:			
<input type="checkbox"/> MARRIED/PARTY TO CIVIL UNION <input type="checkbox"/> DIVORCED <input type="checkbox"/> SINGLE <input type="checkbox"/> WIDOWED					

SECTION 2: NEW ENROLLMENT (Check one, then go to SECTION 4)

New Hire
 Rehire
 Carveout*
 Spouse Turning Age 65* (Attach copy of Medicare Card)
 Open Enrollment
 New Group

Transfer from other VADA Group Name: _____

**Applies to groups with less than 20 employees*

SECTION 3: CHANGE (Check all that apply)

Date of Event: _____
 Birth
 Adoption
 Marriage/Civil Union
 Divorce
 Death
 Loss of Coverage**

Enter/Discharge from Military
 Court Ordered Change**
 Add/Remove Spouse/Civil Union or Dependent (list in Section 4)
 Address Change

Name Change
 Other (explain): _____

***Additional Documentation Required*

SECTION 4: LIST ALL MEMBERS BELOW TO BE ADDED OR REMOVED

IMPORTANT NOTE: Federal Law mandates the collection of SSN for those age 45 and older.

MEMBERSHIP INFORMATION

SUBSCRIBER: <input type="checkbox"/> Add <input type="checkbox"/> Remove <input type="checkbox"/> Health <input type="checkbox"/> Dental	LAST NAME:	FIRST NAME:
	SSN:	DATE OF BIRTH:
SPOUSE/CIVIL UNION PARTNER: <input type="checkbox"/> Add <input type="checkbox"/> Remove <input type="checkbox"/> Health <input type="checkbox"/> Dental	LAST NAME:	FIRST NAME:
	SSN:	DATE OF BIRTH:
DEPENDENT CHILD: <input type="checkbox"/> Add <input type="checkbox"/> Remove <input type="checkbox"/> Health <input type="checkbox"/> Dental <input type="checkbox"/> Incapacitated dependent 26/older	LAST NAME:	FIRST NAME:
	SSN:	DATE OF BIRTH:
DEPENDENT CHILD: <input type="checkbox"/> Add <input type="checkbox"/> Remove <input type="checkbox"/> Health <input type="checkbox"/> Dental <input type="checkbox"/> Incapacitated dependent 26/older	LAST NAME:	FIRST NAME:
	SSN:	DATE OF BIRTH:
DEPENDENT CHILD: <input type="checkbox"/> Add <input type="checkbox"/> Remove <input type="checkbox"/> Health <input type="checkbox"/> Dental <input type="checkbox"/> Incapacitated dependent 26/older	LAST NAME:	FIRST NAME:
	SSN:	DATE OF BIRTH:
DEPENDENT CHILD: <input type="checkbox"/> Add <input type="checkbox"/> Remove <input type="checkbox"/> Health <input type="checkbox"/> Dental <input type="checkbox"/> Incapacitated dependent 26/older	LAST NAME:	FIRST NAME:
	SSN:	DATE OF BIRTH:

PLEASE SEE SECTION 10 ON REVERSE SIDE FOR SUBSCRIBER SIGNATURE

SECTION 5: LIFE INSURANCE BENEFITS

LIFE INSURANCE OPTION:	PRIMARY BENEFICIARY:	SECONDARY BENEFICIARY:	SALARY (1X SALARY ONLY):
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SECTION 6: HEALTH INSURANCE BENEFITS

HEALTH PLAN OPTION:	BCBSVT GROUP NO:	HEALTH PLAN TYPE: <input type="checkbox"/> 1 PERSON <input type="checkbox"/> 2 PERSON <input type="checkbox"/> FAMILY <input type="checkbox"/> REFUSAL
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NEW EMPLOYEES ONLY – Do you have existing health care coverage that you are replacing with this coverage? Yes No

SECTION 7: DENTAL INSURANCE BENEFITS

DENTAL PLAN OPTION:	NEDD GROUP NO:	DENTAL PLAN TYPE: <input type="checkbox"/> 1 PERSON <input type="checkbox"/> 2 PERSON <input type="checkbox"/> FAMILY <input type="checkbox"/> NO BENEFIT
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SECTION 8: SHORT-TERM DISABILITY INCOME BENEFITS

<input type="checkbox"/> NO BENEFITS	BENEFIT TYPE: <input type="checkbox"/> 60% to \$ _____ OR <input type="checkbox"/> 66 2/3% to \$ _____	WEEKLY EARNINGS:
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SECTION 9: OTHER INSURANCE

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) No

MEDICARE

NAME OF MEDICARE SUBSCRIBER:	SOCIAL SECURITY NO.:	MEDICARE/HIC NO.:	PART A EFFECTIVE DATE:	PART B EFFECTIVE DATE:
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HEALTH**DENTAL**

HEALTH INSURANCE COMPANY NAME:	DENTAL INSURANCE COMPANY NAME:
ADDRESS:	ADDRESS:

POLICY HOLD NAME:	POLICY/CERTIFICATE NO:	POLICY HOLD NAME:	POLICY/CERTIFICATE NO:
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EFFECTIVE DATE:	TYPE OF COVERAGE: <input type="checkbox"/> 1 PERSON <input type="checkbox"/> 2 PERSON <input type="checkbox"/> FAMILY	EFFECTIVE DATE:	TYPE OF COVERAGE: <input type="checkbox"/> 1 PERSON <input type="checkbox"/> 2 PERSON <input type="checkbox"/> FAMILY
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SECTION 10: SUBSCRIBER & GROUP BENEFIT MANAGERS 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 my employer to provide information about my employment to the VADA Insurance Trust for purpose of verifying or determining my eligibility for benefits. I certify that I am a regularly-scheduled employee of a member of VADA. 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 VADA Insurance Trust. I UNDERSTAND THAT MY BENEFITS ARE GOVERNED BY THE PROVISIONS OF MY CERTIFICATE AND OUTLINE OF COVERAGE.

SIGN HERE

→ Subscriber's Signature _____ Date _____

→ Group Benefit Manager _____ Date _____

Email completed form to: vtada2@comcast.net **Fax to:** (802) 229-5696 **or Mail to:** **VADA**
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Montpelier, VT 05602