GROUP ENROLLMENT / CHANGE FORM

Employee's First Name	Employee's Last Name

SECTION 1: EMPLOYER / EMPLOYEE INFORMATION

EMPLOYER Name:				Waiting Period: Days
SSN:	Date of Birth:	Gender:	FT or PT:	Home EMAIL address for delivery of benefit plan documents:
Mailing Address:		City:	State:	Zip:
Date of Hire/Rehire/or Became Full Time:	Effective Date (VADA use only):	Marital Status: Married Party to a Civil Union Domestic Partner Divorced Single		

SECTION 2: NEW ENROLLMENT

New Hire Rehire (if within 6 months) Open Enrollment New Group

Transfer from other VADA Group Name: _____

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 Address Change

Name Change Other (explain): _____ ***Additional Documentation Required*

SECTION 4: LIST ALL DEPENDENTS BELOW

Subscriber: Add Health Dental Vision	Last Name: First Name:	**Primary Care Physician (PCP) Information** PCP Name Are you a current Patient? PCP/NCI # Yes No
Spouse/CU Partner/Dom. Partner Add Remove Health Dental Vision	Last Name: Female First Name: Male SSN:*** Date of Birth	**Primary Care Physician (PCP) Information** PCP Name Are you a current Patient? PCP/NCI # Yes No
Dependent Child: Add Remove Health Dental Vision Incap dependent 26/older	Last Name: Female First Name: Male SSN: Date of Birth	**Primary Care Physician (PCP) Information** PCP Name Are you a current Patient? Yes No PCP/NCI #
Dependent Child: Add Remove Health Dental Vision Incap dependent 26/older	Last Name: Female First Name: Male SSN: Date of Birth	**Primary Care Physician (PCP) Information** PCP Name Are you a current Patient? Yes No PCP/NCI #
Dependent Child: Add Remove Health Dental Vision Incap dependent 26/older	Last Name: Female First Name: Male SSN: Date of Birth:	**Primary Care Physician (PCP) Information** PCP Name Are you a current Patient? Yes No PCP/NCI #
Dependent Child: Add Remove Health Dental Vision Incap dependent 26/older	Last Name: Female First Name: Male SSN: Date of Birth:	**Primary Care Physician (PCP) Information** PCP Name Are you a current Patient? Yes No PCP/NCI #

PLEASE SEE SECTION 11 ON REVERSE SIDE FOR SUBSCRIBER SIGNATURE

*** = SSN required age 45 and older (federal mandate requires the collection of SSN

SECTION 5: LIFE INSURANCE BENEFITS

Life Insurance Option: $5K, $10K, $15K, $25, $50K	Primary Beneficiary:	Secondary Beneficiary:	Annual Salary:

SECTION 6: HEALTH INSURANCE BENEFITS

Health Plan Option:	BCBSVT Group No:	BCBSVT Division Code:	Health Plan Type: 1 Person 2 Person Family Refusal

NEW EMPLOYEES ONLY – Do you have existing healthcare coverage that you are replacing with this coverage? Yes No

SECTION 7: DENTAL INSURANCE BENEFITS

Dental Plan Option:	NEDD Group No:	Dental Plan Type: 1 Person 2 Person Family No Benefit
YES		

SECTION 8: DELTAVISION INSURANCE BENEFITS

Vision Plan Option:	DeltaVision Sublocation:	Vision Plan Type: 1 Person 2 Person Family No Benefit
$130 $180		

SECTION 9: SHORT-TERM DISABILITY INCOME BENEFITS

Benefit Plan Option:	Weekly Earnings:	No Benefit
YES - 60% to $300		

SECTION 10: 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(s) below) No

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 11: EMPLOYEE & GROUP BENEFIT MANAGER SIGNATURES

I certify that the statements on this enrollment form 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 work for a Participating Company for a minimum of 17.5 hours per week or the minimum number of hours per week required by my employer for eligibility, whichever is more; and that I perform my work at a Participating Company's VADA member business location. 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 issued by VADA Insurance Trust. I UNDERSTAND THAT MY BENEFITS ARE GOVERNED BY THE PROVISIONS OF MY CERTIFICATE AND OUTLINE OF COVERAGE.

SIGN HERE:

Employee/Subscriber's Signature _____ Date _____

Group Benefit Manager's Signature _____ Date _____

Email completed form to Kim Gauthier using your secure email through Sharefile or fax to: (802) 461-2659 11/23