ENROLLMENT/CHANGE FORM ___ VERMONT EMPLOYEE MEDICAL/DENTAL

Coverage Begins on the 31st day after the date of hire. If this form is submitted between the 31st and 60th day after date of hire, coverage is effective on the date this form is received by the Benefits Division.

❖ EMPLOYEE INFORMATION

Name: _____ Employee ID:_____

Date of Birth:_____ SSN: _____

Home Phone:_____ Work Phone:_____

Return all completed forms to:
STATE OF VERMONT
EMPLOYEE BENEFITS UNIT
144 STATE STREET
MONTPELIER, VT 05620-1701

❖ ACTION REQUEST

☐ New Hire ☐ Open Enrollment ☐ Remove/Add Dependent ☐ Cancel Coverage

If Add/Remove, please give reason and effective date (i.e. Birth, Death, Marriage, Divorce and Date)

_____

_____

❖ STATUS

☐ Single ☐ Married* ☐ Domestic Partner ☐ Widowed ☐ Divorced ☐ Dissolution Domestic Partnership or Civil Union If status has changed, please provide date of event _____

* Married same-sex individuals need to complete and submit a Qualified Dependent Declaration with this application

YOU ARE REQUIRED TO SUBMIT PROOF OF QUALIFYING EVENT TO ADD DEPENDENTS
(E.g. Marriage License, Birth Certificate, Adoption Verification, Domestic Partner Application)

❖ BENEFITS

☐ I select the MEDICAL & DENTAL coverage to the Right (Complete 1, 2, & 3 & Dependent section below)

☐ I select DENTAL ONLY (Provided at no cost to employees)

#1. CHOOSE MEDICAL PLAN
- ☐ SelectCare POS
- ☐ TotalChoice
- ☐ HealthGuard PPO

#2. CHOOSE COVERAGE
- ☐ Employee Only
- ☐ Two Person
- ☐ Family (Employee + 2 or more)

#3. DENTAL COVERAGE
- ☐ Employee Only
- ☐ Two Person
- ☐ Family (Employee +2 or more)

PLEASE PROVIDE ALL REQUESTED INFORMATION BELOW AND SIGN THE NEXT PAGE

❖ YOU & DEPENDENTS

RELATIONSHIP CODES: Spouse = SP; Child = CH; Same-sex Spouse, Domestic or Civil Union Partner = NQP

Fill in your own information on the first line. Your dependents include your spouse, civil union partner, qualified domestic partner, children under age 26, including children of your civil union or qualified domestic partner.

	Coverage Election Medical	Coverage Election Dental	Person Has Other Insurance
Employee Coverage	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N

SelectCare Provider ID: _____ Existing Patient? ☐ Y ☐ N

	Coverage Election Medical	Coverage Election Dental	Person Has Other Insurance
Name: _____	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N

Relationship: _____ Date of Birth: _____ ☐ Male ☐ Female SSN: _____

SelectCare Provider ID: _____ Existing Patient? ☐ Y ☐ N

	Coverage Election Medical	Coverage Election Dental	Person Has Other Insurance
Name: _____	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N

Relationship: _____ **Date of Birth:** _____ ☐ **Male** ☐ **Female** **SSN:** _____

SelectCare Provider ID: _____ **Existing Patient?** ☐ Y ☐ N

	Coverage Election Medical	Coverage Election Dental	Person Has Other Insurance
Name: _____	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N

Relationship: _____ **Date of Birth:** _____ ☐ **Male** ☐ **Female** **SSN:** _____

SelectCare Provider ID: _____ **Existing Patient?** ☐ Y ☐ N

	Coverage Election Medical	Coverage Election Dental	Person Has Other Insurance
Name: _____	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N

Relationship: _____ **Date of Birth:** _____ ☐ **Male** ☐ **Female** **SSN:** _____

SelectCare Provider ID: _____ **Existing Patient?** ☐ Y ☐ N

	Coverage Election Medical	Coverage Election Dental	Person Has Other Insurance
Name: _____	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N

Relationship: _____ **Date of Birth:** _____ ☐ **Male** ☐ **Female** **SSN:** _____

SelectCare Provider ID: _____ **Existing Patient?** ☐ Y ☐ N

	Coverage Election Medical	Coverage Election Dental	Person Has Other Insurance
Name: _____	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N

Relationship: _____ **Date of Birth:** _____ ☐ **Male** ☐ **Female** **SSN:** _____

SelectCare Provider ID: _____ **Existing Patient?** ☐ Y ☐ N

FOR MORE THAN 5 DEPENDENTS USE SECOND FORM

I hereby request the above action and authorize the Department of Human Resources to withhold from my wages appropriate deduction(s), if any, toward the cost of coverage. I understand that any medical information that is pertinent and necessary for the payment of claims for me or my eligible dependents can be used in accordance with the privacy rules established by the Health Insurance Portability and Accountability Act. I certify that the above information is complete and correct and that all claims submitted will only be for eligible plan members.

EMPLOYEE SIGNATURE: _____ **DATE:** _____