BlueCross BlueShield of Vermont
An Independent Licensee of the Blue Cross and Blue Shield Association

GROUP ENROLLMENT FORM

Effective Date _______ / _______ / _______

Student Group Subscriber Application

Return this form to:
Lori Campbell
Student Insurance Administrator
Vermont Law School
PO Box 96
South Royalton VT 05068

All information must be provided.
Please print in ink or type.

Section 1: Group Information

Group No. Section: 23759
Group Name: Vermont Law School Plan

Section 2: Subscriber Coverage Information (For All Transactions)

Name (Last, First, Initial ____________________

Social Security No. ____________________ Date of Birth ____________________

Sex
☐ Male
☐ Female

Marital Status
☐ Single
☐ Married
☐ Widowed
☐ Divorced
☐ Legal Separated

Mailing Address ____________________

Desired Membership Type
☐ 1-Person ☐ 2-Person ☐ Family

City, State, Zip Code ____________________

Home Phone No. ____________________

Plan Coverage ☐A ☐B

Section 3: Dependent Information

Add	Del	List ALL Eligible Dependents	SS#	Sex	Date of Birth	Relationship: Natural or Adopted	Relationship: Step-child	Reside with Subscriber? If Yes, Documents not Required	Subscriber Responsible for Support? If Yes, Documents Required	Full-time Students Age 19-25	Incapacitated? If Yes, Certificate Required
☐	☐			☐ M ☐ F		Spouse					
☐	☐			☐ M ☐ F		☐	☐	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No
☐	☐			☐ M ☐ F		☐	☐	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No
☐	☐			☐ M ☐ F		☐	☐	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No
☐	☐			☐ M ☐ F		☐	☐	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No
☐	☐			☐ M ☐ F		☐	☐	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No

*If your child is adopted, document is required.

Section 4: Signature

I certify that the statement on this application and all information furnished by me are true and complete to the best of my knowledge. I authorize any health care provider disclose to Blue Cross 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 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. If I apply for managed care option, I (we) fully understand that in order to receive the Preferred Level of Benefits my (our) Primary Physician(s) must provide or preauthorize all medical and hospital care, except in life threatening emergencies while away from home and as specified in my (our) Certificate of Outline of Coverage.

Subscribers Signature ____________________ Date ____________________

FOR OFFICE USE ONLY

Effective Date ____________________ By ____________________