



ENROLLMENT/CHANGE FORM

Employer Name	CIGNA Acct # (a 4-digit number)	Subscriber Social Security Number	Effective Date	Plan Type <input type="checkbox"/> Active <input type="checkbox"/> COBRA <input type="checkbox"/> Retiree*
Subscriber Name (First Middle Last)	Sub Date of Hire	Sub Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Sub Date of Birth	*Medicare ID # _____ suffix
Subscriber Mailing Address (Street, City, State, Zip Code)				

Reason for Form (check all that apply)

<input type="checkbox"/> New Hire	<input type="checkbox"/> Cancel Subscriber above	<input type="checkbox"/> Plan/Benefit Option Change
<input type="checkbox"/> Open Enrollment	<input type="checkbox"/> Transfer subscriber above to COBRA	<input type="checkbox"/> Other/Reason _____
<input type="checkbox"/> Add Dependent(s) listed below	<input type="checkbox"/> Transfer subscriber above to Med Carveout	_____
<input type="checkbox"/> Cancel Dependent(s) listed below	<input type="checkbox"/> Address Change	_____
<input type="checkbox"/> Change Subscriber above Status to "Retiree"		

NOTE: Eff 1/1/2011 dependents up to age 26 may be covered without proof of full-time student status.

Spouse Name (First Middle Last)	Spouse Date of Birth	Spouse Social Security Number	Spouse Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	If FT student (12 credit hours per semester) age 19 to 25 please provide proof of FT student status such as tuition bill or course transcript (pre 1/1/11 only).
Dependent Name (First Middle Last)	Dependent DOB	Dependent Social Security Number	Dependent Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	
			<input type="checkbox"/> Male <input type="checkbox"/> Female	Full Time Student age 19 to 25? (see above) <input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Yes <input type="checkbox"/> No

Benefit Plan: For new enrollees or subscriber plan changes, please check the appropriate plan code below. Your Benefits Administrator can tell you which plan(s) your employer offers.

<p>VLCT Plan Name</p> <p>Gold B Medicare Carveout HP 10/20 B HP 10/20 C HP 20/30 B HDHP \$1,500/\$3,000 HDHP \$2,250/\$4,500 HDHP Value Plan \$1,500/\$3,000 HDHP Value Plan \$2,250/\$4,500 HDHP Value Plan \$3,000/\$6,000</p>	<p>CIGNA's Plan Code</p> <p><input type="checkbox"/> VLRJ2* (retiree coverage only) <input type="checkbox"/> VHPE <input type="checkbox"/> VHPF <input type="checkbox"/> VHPH <input type="checkbox"/> VHSA1 <input type="checkbox"/> VHSA2 <input type="checkbox"/> VVP2 <input type="checkbox"/> VVP3 <input type="checkbox"/> VVP4</p>	<p>VLCT Plan Name</p> <p>OAP 100 B OAP 100 C OAP 200 B OAP 200 C OAP 500 B OAP 500 C Gold B Gold C OTHER _____</p>	<p>CIGNA's Plan Code</p> <p><input type="checkbox"/> VLCTB <input type="checkbox"/> VLCTC <input type="checkbox"/> VLCTE <input type="checkbox"/> VLCTF <input type="checkbox"/> VLCTH <input type="checkbox"/> VLCTI <input type="checkbox"/> VLCJ2 <input type="checkbox"/> VLCJ3</p>
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<p>If you are unsure of your group's particular plan names or benefit options, please contact VLCT Member Relations for assistance in completing the Benefit Plan portion of this form.</p>	<p>Plan Name Description/Detail</p> <p>Letters B and C after the Plan Name represent the associated prescription drug option as follows:</p> <ul style="list-style-type: none"> B = \$100 deductible; \$5 co-pay on generic medications; 25% coinsurance w/ \$50 maximum on preferred meds; and 50% coinsurance w/ \$75 maximum on non-preferred meds. C = \$50 deductible; \$5/\$10/\$25 co-pay on generic/preferred/non-preferred medications.
	<p>Other Health Care Coverage (Please provide names of covered individuals, types of other coverage and effective dates)</p>

Employer Signature	Date	Employee/Subscriber Signature	Date
_____	____/____/____	_____	____/____/____

Send Original to our **Eligibility & Billing Processing Center** at: VLCT Health Trust, PO Box 39, Montpelier, VT 05601-0039 or fax to 802-223-4257. → **Please note that mailing or faxing this form to VLCT's main office will only delay processing.** ←

Give a copy to the subscriber and retain a copy for personnel files. For routine eligibility inquiries, call 800-649-7915 or e-mail kavery@vlct.org. (Rev.10/29/10)