CBA Blue
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P.O. Box 2365
So. Burlington, VT 05407-2365 FAX# (802) 862-7661

LAMOILLE NORTH SUPERVISORY UNION

☐ NEW ENROLLMENT ☐ CHANGE OF STATUS

EMPLOYEE – MUST COMPLETE ALL INFORMATION IN SECTIONS 1 THROUGH 7

SECTION 1 – EMPLOYEE PARTICIPANT INFORMATION

Social Security Number	Last Name ☐ check if new	First Name	MI	Date of Birth

Home Mailing Address ☐ check if new	City	State	Zip Code

Gender ☐ Male ☐ Female	Home Phone	Work Phone	Current Marital Status ☐SINGLE ☐ MARRIED

SECTION 2 – DEPENDENT INFORMTION

	Check One	LAST NAME	FIRST NAME	MI	SEX	DATE OF BIRTH MM/DD/YYYY	SOCIAL SECURITY #	Enter "Dep" Relationship Code
Spouse or Partner	☐Add ☐Delete				☐M ☐F			
Dep-1	☐Add ☐Delete				☐M ☐F			
Dep-2	☐Add ☐Delete				☐M ☐F			
Dep-3	☐Add ☐Delete				☐M ☐F			
Dep-4	☐Add ☐Delete				☐M ☐F			
Dep-5	☐Add ☐Delete				☐M ☐F			

DEP Relationship Codes:
C-Child (Birth/Adoption) **L-**Legal Guardianship* **CO-**Court Order Coverage* **SP-**Spouse
D-Disabled Child (attach Physician Statement **CU-** Civil Union
S-Stepchild***

*= Attach Court Order
*** = Who is legally responsible for stepchild(s) medical bills? _____

SECTION 3 – ENROLLMENT CHOICES

☐ Elect Dental Coverage: ☐ Single ☐ Member/Spouse ☐ Member/1 Child ☐ Member/ 2 or more Children ☐ Family
☐ Waive Coverage

SECTION 4 - SPOUSE EMPLOYER INFORMATION

Is Spouse Employed? ☐Yes ☐ No If yes, provide Name & Address of Employer: _____
Does Spouse's Employer offer dental coverage? ☐ Yes ☐ No

SECTION 5 - OTHER COVERAGE

Do you, your spouse or dependent(s) maintain other dental coverage? ☐ YES ☐ NO If Yes, complete below and provide a copy of the Plan's ID card.

Policyholder Name	Policy Number	Group Number	Insurance Company Name & Address	Effective Date: _____ ☐Single ☐ 2P ☐ Family
Policyholder Name	Policy Number	Group Number	Insurance Company Name & Address	Effective Date: _____ ☐Single ☐ 2P ☐ Family

SECTION 6: HIPAA COMPLIANCE

Will this plan replace existing dental insurance coverage? ☐YES ☐NO **If yes, attach a certificate of prior dental insurance coverage.** Your Prior insurer will give you this form.

SECTION 7: SUBSCRIBER SIGNATURE

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 and any enrolled dependants agree to permit any healthcare provider to release/disclose any information (including Protected Health Information) acquired in connection with any past or future care or treatment to Comprehensive Benefits Administrator, Inc. \ Employee Benefit Plan Administration, Inc., or its designated agent for purposes of administering healthcare coverage.

Subscriber's Signature	**Date**

****EMPLOYER USE ONLY – EMPLOYER CHECK AND COMPLETE APPROPRIATE AREAS BELOW****

COVERAGE EFFECTIVE DATES:	Dental Effective Date:			
EMPLOYEE STATUS:	Date of Hire	or Full Time Status	☐ New Hire ☐ Rehire ☐ Open Enrollment ☐ HIPAA Qualifying Event (describe event): _____	
	Division/Subgroup **LNMUUSD 0926 _____ CES 0927_____ LNSU 0930___**		☐ Full-Time ☐ Part-Time ☐ Retiree	☐ Salary ☐ Hourly - #Hours _____
REASON FOR STATUS CHANGE:	Effective Date:	☐ Marriage ☐ Name Change ☐ Address Change ☐ Open Enrollment ☐ Surviving Spouse ☐ Loss of Coverage (Certificate of Creditable Coverage Required) ☐ Transfer ☐ HIPAA Qualifying Event (describe event): _____		
CANCEL COVERAGE:	Effective Date:	☐ All ☐ Spouse ☐ Dependent(s) list in Section 2	**REASON:** ☐ COBRA ☐ Divorce ☐ Retired ☐ Death ☐ Left Employment ☐ Dependent over Age ☐ Other Insurance ☐ Other describe): _____	