ENROLLMENT/CHANGE FORM __   VERMONT   RETIREE MEDICAL

❖ RETIREE INFORMATION

Name: _____	**Retiree ID:**_____
Date of Birth:_____ ___	**SSN:** _____
Home Phone:_____ ___	**Work Phone:**_____

> **Return all completed forms to:**
> *STATE OF VERMONT*
> *RETIREMENT DIVISION*
> *109 STATE STREET*
> *MONTPELIER, VT 05609-6901*

Street Address: _____   **City, State, Zip:**_____

❖ ACTION REQUEST

☐ **New Retiree**   ☐ **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 _____**

❖ BENEFITS

	#1. CHOOSE MEDICAL PLAN	#2. CHOOSE COVERAGE
☐ **I select the MEDICAL coverage to the RIGHT** (Complete 1, & 2 plus the Dependent section below)	☐ **SelectCare POS** ☐ **TotalChoice**	☐ **Employee Only** ☐ **Two Person** ☐ **Family** (Employee + 2 or more)

☐ **Either myself, my spouse, or (one of) my dependents is eligible for Medicare Part A and/or Part B**

PLEASE PROVIDE ALL REQUESTED INFORMATION BELOW AND SIGN THE NEXT PAGE

❖ YOU & DEPENDENTS - RELATIONSHIP CODES: Spouse = SP; Child = CH; 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, unmarried children under age 26, including children of your civil union or qualified domestic partner.

	Coverage Election		Person Has Other
	Medical	**Medicare-eligible**	**Insurance**
Retiree Coverage	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N

	Coverage Election		Person Has Other
	Medical	**Medicare-eligible**	**Insurance**
Name: _____	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
Relationship: _____	**Date of Birth:** _____	☐ Male ☐ Female	**SSN:** _____

	Coverage Election		**Person Has Other**	
	Medical	**Medicare-eligible**	**Insurance**	
Name: _____	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	
Relationship: _____	Date of Birth: _____	☐ Male ☐ Female	SSN: _____	

	Coverage Election		**Person Has Other**	
	Medical	**Medicare-eligible**	**Insurance**	
Name: _____	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	
Relationship: _____	Date of Birth: _____	☐ Male ☐ Female	SSN: _____	

	Coverage Election		**Person Has Other**	
	Medical	**Medicare-eligible**	**Insurance**	
Name: _____	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	
Relationship: _____	Date of Birth: _____	☐ Male ☐ Female	SSN: _____	

	Coverage Election		**Person Has Other**	
	Medical	**Medicare-eligible**	**Insurance**	
Name: _____	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	
Relationship: _____	Date of Birth: _____	☐ Male ☐ Female	SSN: _____	

	Coverage Election		**Person Has Other**	
	Medical	**Medicare-eligible**	**Insurance**	
Name: _____	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	
Relationship: _____	Date of Birth: _____	☐ Male ☐ Female	SSN: _____	

	Coverage Election		**Person Has Other**	
	Medical	**Medicare-eligible**	**Insurance**	
Name: _____	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	
Relationship: _____	Date of Birth: _____	☐ Male ☐ Female	SSN: _____	

I hereby request the above action and authorize VSRS to deduct my portion of the monthly premium from my retirement check. I understand that my first check will show a double deduction because health insurance premiums must be paid one month in advance. Subsequent checks will show the single deduction. 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.

At age 65 or earlier, in the case of disability benefits paid by Social Security, Medicare will become the primary insurance carrier and state medical premiums will be decreased. Should I or any of my dependents become eligible for Medicare before age 65, I agree to notify the Retirement Office immediately. I also understand that if I do not choose Medicare when available, as my primary insurance carrier, I will be responsible for any medical payments that would have been paid by Medicare.

I certify that the above information is complete and that all claims submitted will only be for eligible plan members.

RETIREE SIGNATURE: _____ DATE: _____