Enrollment Request for Vermont Blue Advantage Group PPO

Please contact Vermont Blue Advantage Group PPO if you need information in another language or format.

Vermont Blue advantage
An Independent Licensee of the Blue Cross and Blue Shield Association.

Select the plan you want to join	For internal use only	
☐ Comprehensive 40724-100 ☐ Plan JY 40725-100 ☐ VSTRS 65 (no Part D drug coverage) 40726-100	Received date	Effective date

Please provide the following information in print

☐ Mr. ☐ Ms. ☐ Mrs.	First name Middle initial Last name		
Birth date (mm/dd/yyyy)	Sex ☐ Male ☐ Female	Phone number	Alternate phone number (optional)
Permanent residence street address (*cannot be a post office box*)		City	State
ZIP code	County (optional)	Email address (optional)	

Mailing address (*if different from your permanent residence address*)

Street address	City	State	ZIP code

Optional information

Emergency contact name	
Relationship to you	Phone number

Please provide your Medicare insurance information

Please take out your **red, white, and blue Medicare card** to complete this section. • Fill out this information as it appears on your Medicare card. OR • Attach a copy of your Medicare card or your letter from Social Security or the Railroad Retirement Board.	Name (as it appears on your Medicare card)	
	Medicare number	
	Is entitled to	Effective date
	HOSPITAL (Part A)	
	MEDICAL (Part B)	
	You must have Medicare Part A and Part B to join a Medicare Advantage plan.	

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1378. The time required to complete this information is estimated to average 20 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

IMPORTANT Do not send this form or any items with your personal information (such as claims, payments, medical records, etc.) to the PRA Reports Clearance Office. Any items we get that aren't about how to improve this form or its collection burden (outlined in OMB 0938-1378) will be destroyed. It will not be kept, reviewed, or forwarded to the plan. See "What happens next?" on this page to send your completed form to the plan.

Please respond to all the questions	
1. Are you the retiree? If yes, retirement date (month/day/year) _____ If no, name of retiree _____	☐ **Yes** ☐ **No**
2. Are you covering a spouse or dependent under this plan? If yes, name of spouse _____ Name(s) of dependent(s) _____	☐ **Yes** ☐ **No**
3. Do you work? **Does your spouse work?**	☐ **Yes** ☐ **No** ☐ **Yes** ☐ **No**
4. Do you have other drug coverage, including other private insurance, workers compensation, VA benefits or state pharmaceutical assistance programs? If yes, please provide the following information. Company name _____ Name of other drug plan _____ ID # for coverage _____	☐ **Yes** ☐ **No**
5. Are you a resident of a long-term care facility, such as a nursing home? If yes, please provide the following information. Name of facility _____ Facility street address _____ City _____ State _____ ZIP code _____ Phone number _____	☐ **Yes** ☐ **No**
6. (Optional) **List your primary care physician (PCP), clinic, or health center** _____	

This enrollment application is part of your Vermont Blue Advantage Group PPO enrollment kit. Other important materials you should review before joining this plan are included with this form:

- A cover letter with important deadlines and information (such as the date your enrollment form is due and where to send it)
- A Benefits-at-a-Glance booklet
- A Centers for Medicare & Medicaid Services Stars Ratings flyer (measures how well Medicare Advantage plans perform in several areas)

Please contact Vermont Blue Advantage PPO Customer Service at **1-800-572-0280** (TTY users call 711) if you need information in an accessible format or language other than what is listed below.

Select one if you want us to send you information in a language other than English.

☐ Spanish ☐ Other _____

Select one if you want us to send you information in an accessible format.

☐ Large print ☐ Audio CD

Customer Service hours are Monday through Friday, 8 a.m. to 8 p.m. Eastern time, with weekend hours October 1 to March 31. You can also visit **www.VermontBlueAdvantage.com**.

[All fields on this page are optional]

[Answering these questions is your choice. You can't be denied coverage because you don't fill them out.]

[Are you Hispanic, Latino/a, or Spanish origin? Select all that apply.

- ☐ No, Not of Hispanic, Latino/a, or Spanish origin
- ☐ Yes, Mexican, Mexican American, Chicano/a
- ☐ Yes, Puerto Rican
- ☐ Yes, Cuban
- ☐ Yes, another Hispanic, Latino/a, or Spanish origin
- ☐ I choose not to answer.]

[What is your race? Select all that apply.]

- ☐ [American Indian or Alaska Native
- ☐ Asian Indian
- ☐ Black or African American
- ☐ Chinese
- ☐ Filipino
- ☐ Guamanian or Chamorro
- ☐ Japanese
- ☐ Korean
- ☐ Native Hawaiian
- ☐ Other Asian
- ☐ Other Pacific Islander
- ☐ Samoan
- ☐ Vietnamese
- ☐ White
- ☐ I choose not to answer.]

Important: Please read and sign below

By completing this enrollment application, I agree to the following:

Vermont Blue Advantage Group PPO is a Medicare Advantage plan and has a contract with the Federal government. I will need to keep my Medicare Parts A and B. I can only be in one Medicare Advantage plan at a time and I understand that my enrollment in this plan will automatically end my enrollment in another Medicare health plan. It is my responsibility to inform the plan of any prescription drug coverage that I have or may get in the future. I understand that if I do not have Medicare prescription drug coverage or creditable prescription drug coverage (as good as Medicare's), I may have to pay a late enrollment penalty if I enroll in Medicare prescription drug coverage in the future.

Enrollment in this plan is generally for the entire year. Once I enroll, I may leave this plan or make changes only at certain times of the year if an enrollment period is available (Example: Annual Enrollment Period from October 15 - December 7), or under certain special circumstances. As a Medicare Advantage PPO member, I understand that Vermont Blue Advantage Group PPO works differently than a Medicare supplemental plan. Vermont Blue Advantage Group PPO pays instead of Medicare, and I will be responsible for the amounts that Vermont Blue Advantage Group PPO does not cover, such as copayments or coinsurances. Original Medicare will not pay for my health care while I am enrolled in Vermont Blue Advantage Group PPO.

Before seeing a provider, I should verify that the provider will accept Medicare. I understand that if my provider does not accept Medicare, I will need to find another provider who will, or my out-of-pocket costs may be greater. Out-of-network/non-contracted providers are under no obligation to treat Vermont Blue Advantage Group PPO members, except in emergency situations. For a decision about whether we will cover an out-of-network service, we encourage you or your provider to ask us for a pre-service organization determination before you receive the service. Please call our customer service number or see your *Evidence of Coverage* for more information, including the cost-sharing that applies to out-of-network services.

Vermont Blue Advantage Group PPO serves a specific service area. If I move out of the area that Vermont Blue Advantage Group PPO serves, I need to notify the plan so I can disenroll and find a new plan in my new area. Once I am a member of Vermont Blue Advantage Group PPO, I have the right to appeal plan decisions about payment or services if I disagree. I will read the *Evidence of Coverag*e document from Vermont Blue Advantage Group PPO when I receive it to know which rules I must follow in order to receive coverage with this Medicare Advantage plan. I understand that people with Medicare aren't usually covered under Medicare while out of the country except for limited coverage near the U.S. border.

I understand that if I am receiving assistance from a sales agent, broker, or other individual employed by or contracted with Vermont Blue Advantage Group PPO, he/she may be paid based on my enrollment in Vermont Blue Advantage Group PPO.

Counseling services may be available in my state to provide advice concerning Medicare supplement insurance or other Medicare Advantage or Prescription Drug plan options, medical assistance through the State Medicaid Program and the Medicare Savings Program.

Release of Information: By joining this Medicare health plan, I acknowledge that Vermont Blue Advantage Group PPO will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that Vermont Blue Advantage Group PPO will release my information, including my prescription drug event data, to Medicare, who may release it for research and other purposes that follow all applicable federal statutes and regulations. The information on this enrollment form is correct to the best of my knowledge. I understand that if I intentionally provide false information on this form, I will be disenrolled from the plan.

I understand that my signature (or the signature of the person authorized to act on my behalf under the laws of the state where I live) on this application means that I have read and understand the contents of this application. If signed by an authorized individual (as described above), this signature certifies that: 1) this person is authorized under state law to complete this enrollment and 2) documentation of this authority is available upon request by Vermont Blue Advantage Group PPO or by Medicare.

Please sign below. By signing below, you have read the above information and you acknowledge you received a cover letter with this form as well as a Benefits-at-a-Glance booklet and Star Rating flyer.			
Signature		Today's date	
If you are the authorized representative, you must sign above and provide the following information.			
Name			
Address			
City		State	ZIP code
Phone number	Relationship to enrollee		

Please send your completed enrollment application to:

Vermont State Teachers' Retirement System
109 State Street, 4th Floor
Montpelier, VT 05609-6901

Fax: 802-828-5182

Or email to: TRE.RetirementBenefitPayroll@vermont.gov

PRIVACY ACT STATEMENT
The Centers for Medicare & Medicaid Services (CMS) collects information from Medicare plans to track beneficiary enrollment in Medicare Advantage (MA) Plans, improve care, and for the payment of Medicare benefits. Sections 1851 of the Social Security Act and 42 CFR §§ 422.50 and 422.60 authorize the collection of this information. CMS may use, disclose and exchange enrollment data from Medicare beneficiaries as specified in the System of Records Notice (SORN) "Medicare Advantage Prescription Drug (MARx)", System No. 09-70-0588. Your response to this form is voluntary. However, failure to respond may affect enrollment in the plan.