

GROUP SUBSCRIBER
MEDICARE SUPPLEMENT
APPLICATION AND
CHANGE FORM

All Information Must be
Provided, Please Print in
Ink or Type

Please choose one:
 JY Carveout 300 Carveout VT BlueCS Carveout

SECTION 1: GROUP INFORMATION

GROUP NO. - SECTION 80724-	DATE OF HIRED	EMPLOYMENT STATUS <input type="checkbox"/> ACTIVE <input checked="" type="checkbox"/> RETIRED
GROUP NAME USTRS	PROBATIONARY PERIOD DAYS	

A PHOTOCOPY OF YOUR MEDICARE CARD MUST BE ENCLOSED

SECTION 2: SUBSCRIBER COVERAGE INFORMATION (FOR ALL TRANSACTIONS)

NAME (LAST, FIRST, INITIAL)	SOCIAL SECURITY NO.	DATE OF BIRTH
STREET ADDRESS	HOME PHONE NO.	SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
CITY, STATE, ZIP CODE	MARITAL STATUS <input type="checkbox"/> MARRIED/PARTY TO A CIVIL UNION <input type="checkbox"/> SINGLE <input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED	

SECTION 3: REASON FOR FORM (check applicable boxes and indicate dates as M/D/Y)

REASON FOR CHANGE:	APPLICATION	Date of Event	CANCELLATION	Date of Event
<input type="checkbox"/> Change of Address	<input type="checkbox"/> Full Time Hire/Rehire	/ /	<input type="checkbox"/> Voluntary Cancel	/ /
<input type="checkbox"/> Change of Name	<input type="checkbox"/> Transfer from other BCBS Plan		<input type="checkbox"/> Obtained Other Coverage	
<input type="checkbox"/> Other	<input type="checkbox"/> Tumed.65		<input type="checkbox"/> Retired - Transfer to Nongroup Coverage	
<input checked="" type="checkbox"/> Open Enrollment			<input type="checkbox"/> Death	

SECTION 4: QUESTIONS

(1) To the best of your knowledge, do you have another Medicare supplement policy or certificate in force (including health care service contract, health maintenance organization (HMO) contract)? If yes, with which company? Yes No

INSURANCE COMPANY (NAME AND ADDRESS)

POLICY HOLDER NAME

POLICY NO. GROUP NO. EFFECTIVE DATE

(2) To the best of your knowledge, do you have any other health insurance policies that provide benefits which this Medicare supplement policy would duplicate? If yes, with which company? Yes No

INSURANCE COMPANY (NAME AND ADDRESS)

POLICY HOLDER NAME

POLICY NO. GROUP NO. EFFECTIVE DATE

What kind of policy?

3) If the answer to question 1 or 2 is yes, do you intend to replace these medical or health policies with this policy? Yes No

4) Are you covered by Medicaid? Yes No

SECTION 5: STATEMENTS

- You do not need more than one Medicare supplement policy.
- If you are 65 or older, you may be eligible for benefits under Medicaid and may not need a Medicare supplement policy.
- The benefits and premiums under your Medicare supplement policy will be suspended during your entitlement to benefits under Medicaid for 24 months. You must request this suspension within 90 days of becoming eligible for Medicaid. If you are no longer entitled to Medicaid, your policy will be reinstated if requested within 90 days of losing Medicaid eligibility.
- Counseling services may be available to provide advice concerning your purchase of Medicare supplement insurance and concerning Medicaid.

SECTION 6: SIGNATURE

certify that the statements 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 to 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. 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 Blue Shield of Vermont.

SUBSCRIBER'S SIGNATURE	DATE	FOR OFFICE USE ONLY	EFFECTIVE DATE	BY
	/ /		/ /	