

# State of Vermont

## Retiree Medical Plan Enrollment Form



**ACTION REQUEST**

(Please Circle One)

New Retiree

Open Enrollment

Add/Remove Dependents  
Date of Add/Remove/Cancel: \_\_\_\_\_

Cancel Coverage

RETIREE NAME: \_\_\_\_\_ RETIREE ID: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_ SSN: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ GENDER: M / F

(street)

(city/st/zip) \_\_\_\_\_

HOME PHONE: \_\_\_\_\_ WORK PHONE: \_\_\_\_\_

Return all completed forms to:  
STATE OF VERMONT  
RETIREMENT DIVISION  
109 State Street  
Montpelier, VT 05609-6901

❖ **STATUS**

Single  Married\*  Domestic Partner  Widowed  Divorced  Dissolution Domestic Partnership or Civil Union  
If status has changed, please provide date of event \_\_\_\_\_

\* Married same-sex individuals need to complete and submit a Qualified Dependent Declaration with this application

❖ **BENEFITS**

#1. CHOOSE MEDICAL PLAN

#2. CHOOSE COVERAGE

I select the MEDICAL Coverage to the RIGHT →  
Please (Complete 1, & 2 & Dependent section below)

SelectCare POS  
 TotalChoice  
 HealthGuard PPO  
 SafetyNet\*\*

Retiree Only  
 Two Person  
 Family  
(Employee + 2 or more)

**\*\*Medicare-eligible Retirees can enroll in any plan EXCEPT the SafetyNet Plan.**

PLEASE PROVIDE ALL REQUESTED INFORMATION BELOW AND SIGN THE NEXT PAGE

❖ **YOU & DEPENDENTS**

RELATIONSHIP CODES: Spouse = SP; Child = CH; Same-sex Spouse, 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 19 (or to age 26, if they do not have the offer of insurance through an employer), including children of your civil union or qualified domestic partner.

	<b>Coverage Election Type</b>	<b>Other Insurance?</b>
RETIREE Coverage	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
Medicare HIC#: _____		

	<b>Coverage Election Type</b>	<b>Person Has Other Insurance?</b>	<b>Relationship</b>
Name: _____	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	_____
Medicare HIC#: _____	Date of Birth: _____	<input type="checkbox"/> Male <input type="checkbox"/> Female	SSN: _____
	<b>Coverage Election Type</b>	<b>Person Has Other Insurance?</b>	<b>Relationship</b>
Name: _____	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	_____
Medicare HIC#: _____	Date of Birth: _____	<input type="checkbox"/> Male <input type="checkbox"/> Female	SSN: _____

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	Coverage Election Type	Person Has Other Insurance?	Relationship
Name: _____	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	_____
Medicare HIC#: _____	Date of Birth: _____	<input type="checkbox"/> Male <input type="checkbox"/> Female	SSN: _____

	Coverage Election Type	Person Has Other Insurance?	Relationship
Name: _____	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	_____
Medicare HIC#: _____	Date of Birth: _____	<input type="checkbox"/> Male <input type="checkbox"/> Female	SSN: _____

	Coverage Election Type	Person Has Other Insurance?	Relationship
Name: _____	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	_____
Medicare HIC#: _____	Date of Birth: _____	<input type="checkbox"/> Male <input type="checkbox"/> Female	SSN: _____

	Coverage Election Type	Person Has Other Insurance?	Relationship
Name: _____	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	_____
Medicare HIC#: _____	Date of Birth: _____	<input type="checkbox"/> Male <input type="checkbox"/> Female	SSN: _____

	Coverage Election Type	Person Has Other Insurance?	Relationship
Name: _____	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	_____
Medicare HIC#: _____	Date of Birth: _____	<input type="checkbox"/> Male <input type="checkbox"/> 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 one of my dependents become eligible for Medicare before age 65, I agree to notify the Retirement Office immediately. I also understand that that if I do not choose Medicare when available, as my primary insurance carrier, I will be responsible for any medical payment that would have been paid by Medicare.

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

\_\_\_\_\_  
RETIREE SIGNATURE

\_\_\_\_\_  
DATE SIGNED