

❖ RETIREE INFORMATION

Name: \_\_\_\_\_ Person 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

❖ ACTION REQUEST

New Retiree     Annual Open Enrollment     Remove/Add Dependent     Cancel Coverage  
If Remove/Add, please give a 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 →  
Please (Complete 1 & 2 plus the  
Dependent section below)

SelectCare POS  
 TotalChoice  
 HealthGuard PPO

Retiree Only  
 Two Person  
 Family Plan  
(Retiree + 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, 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. If you choose the SelectCare POS Plan, please indicate a Provider ID number and whether each dependent is a patient of this physician. Provider ID numbers can be found on the medical carriers website.

	Coverage Election		Person Has Other Insurance
	Medical	Medicare-eligible	
Retiree Coverage	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
SelectCare Provider ID: _____		Existing Patient? <input type="checkbox"/> Y <input type="checkbox"/> N	

Name: _____	Coverage Election		Person Has Other Insurance	Enrolled as a Full-time Student
	Medical	Dental		
	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
Relationship: _____		Date of Birth: _____	<input type="checkbox"/> Male <input type="checkbox"/> Female	SSN: _____
SelectCare Provider ID: _____		Existing Patient? <input type="checkbox"/> Y <input type="checkbox"/> N		

Name: _____	Coverage Election		Person Has Other Insurance <input type="checkbox"/> Y <input type="checkbox"/> N	Enrolled as a Full-time Student <input type="checkbox"/> Y <input type="checkbox"/> N
	Medical <input type="checkbox"/> Y <input type="checkbox"/> N	Dental <input type="checkbox"/> Y <input type="checkbox"/> N		
Relationship: _____	Date of Birth: _____		<input type="checkbox"/> Male <input type="checkbox"/> Female	SSN: _____
SelectCare Provider ID: _____			Existing Patient? <input type="checkbox"/> Y <input type="checkbox"/> N	

Name: _____	Coverage Election		Person Has Other Insurance <input type="checkbox"/> Y <input type="checkbox"/> N	Enrolled as a Full-time Student <input type="checkbox"/> Y <input type="checkbox"/> N
	Medical <input type="checkbox"/> Y <input type="checkbox"/> N	Dental <input type="checkbox"/> Y <input type="checkbox"/> N		
Relationship: _____	Date of Birth: _____		<input type="checkbox"/> Male <input type="checkbox"/> Female	SSN: _____
SelectCare Provider ID: _____			Existing Patient? <input type="checkbox"/> Y <input type="checkbox"/> N	

Name: _____	Coverage Election		Person Has Other Insurance <input type="checkbox"/> Y <input type="checkbox"/> N	Enrolled as a Full-time Student <input type="checkbox"/> Y <input type="checkbox"/> N
	Medical <input type="checkbox"/> Y <input type="checkbox"/> N	Dental <input type="checkbox"/> Y <input type="checkbox"/> N		
Relationship: _____	Date of Birth: _____		<input type="checkbox"/> Male <input type="checkbox"/> Female	SSN: _____
SelectCare Provider ID: _____			Existing Patient? <input type="checkbox"/> Y <input type="checkbox"/> N	

Name: _____	Coverage Election		Person Has Other Insurance <input type="checkbox"/> Y <input type="checkbox"/> N	Enrolled as a Full-time Student <input type="checkbox"/> Y <input type="checkbox"/> N
	Medical <input type="checkbox"/> Y <input type="checkbox"/> N	Dental <input type="checkbox"/> Y <input type="checkbox"/> N		
Relationship: _____	Date of Birth: _____		<input type="checkbox"/> Male <input type="checkbox"/> Female	SSN: _____
SelectCare Provider ID: _____			Existing Patient? <input type="checkbox"/> Y <input type="checkbox"/> N	

Name: _____	Coverage Election		Person Has Other Insurance <input type="checkbox"/> Y <input type="checkbox"/> N	Enrolled as a Full-time Student <input type="checkbox"/> Y <input type="checkbox"/> N
	Medical <input type="checkbox"/> Y <input type="checkbox"/> N	Dental <input type="checkbox"/> Y <input type="checkbox"/> N		
Relationship: _____	Date of Birth: _____		<input type="checkbox"/> Male <input type="checkbox"/> Female	SSN: _____
SelectCare Provider ID: _____			Existing Patient? <input type="checkbox"/> Y <input type="checkbox"/> N	

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 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 SIGNED