STATE OF VERMONT UNDER 65 RETIREE MEDICAL PLAN OPTIONS
REQUEST TO CHANGE, ADD, REMOVE, OR CANCEL INSURANCE COVERAGE

GENERAL INFORMATION

Use this form to:

- **CHANGE Medical Insurance only during the annual Open Enrollment period.**
- **Either ADD new dependents or REMOVE existing dependents from your coverage. To ENROLL a dependent for coverage, you must submit this form within 60 days after the dependent becomes eligible.**
- **CANCEL coverage for yourself and dependents.**

Once completed, send to:

State of Vermont, Retirement Division,
109 State Street, Montpelier, VT 05609-6901

HOW TO USE THIS FORM

1. **REQUEST FOR ACTION – Please circle the type of action you are requesting.**

   - **OPEN ENROLLMENT – Circle this if you are changing plans during the annual Open Enrollment period.**

   - **ADD DEPENDENT – Circle this when adding a dependent to your coverage. To enroll a dependent for coverage, you must submit this form within 60 days after the dependent becomes eligible. If your dependent(s) recently lost insurance coverage under another group health plan, coverage can be effective immediately if you include the following information with your application: a letter from the former employer or insurance carrier indicating (a) who was covered under the plan, (b) the date coverage ended (it must have occurred within 60 days of this request), (c) the reason coverage ended, and (d) the name of the insurance carrier or claims service provider.**

   - **REMOVE DEPS – Circle this when you are removing a dependent from your coverage.**

   - **CANCEL COV – Circle this when you are canceling coverage for yourself AND all dependents.**

2. **RETIREE INFORMATION – All necessary information in this section must be completed or this form will be returned to you for completion. If your home phone is an unlisted number and you wish to have it remain confidential, you may leave it blank.**

3. **CHOICE OF MEDICAL PLANS – State Retirees under 65 and not eligible for Medicare have a choice of four medical plans. They are the "TotalChoice Plan", "SelectCare POS Plan", "HealthGuard PPO Plan", or the "SafetyNet Plan". If you are not Medicare eligible, and have selected SelectCare POS Plan, YOU MUST ALSO COMPLETE THE PROVIDER (DOCTOR) ID NUMBER SECTION. YOUR APPLICATION CANNOT BE PROCESSED WITHOUT THIS INFORMATION. If you are eligible for Medicare, you can only choose to enroll in the TotalChoice Plan or the HealthGuard Plan. If you have questions or need information about the plans, please contact the Retirement Division at (802) 828-2305.**

4. **CHOICE OF COVERAGE TYPE – Check the appropriate box to indicate the type of coverage being requested.**

5. **DEPENDENT INFORMATION – In this section, complete all necessary information any time you request coverage for eligible dependents or for a dependent to be removed from coverage. Dependents include your spouse, civil union partner, qualified domestic partner, unmarried children (including children of your civil union partner or qualified domestic partner) under age 19, or to age 23, if a full-time student. If additional space is needed, please attach a sheet of paper with the same information for each person. The value of the coverage for dependents who are not within the U.S. Tax Code definition of a dependent will be considered as income on which taxes must be paid**

   If you have chosen the SelectCare POS Plan, you must also complete the Provider ID Number section for your dependents. Your application cannot be processed without this information. A list of Providers for this plan can be obtained through the Retirement Division.

   For full-time students age 19 but under age 23, you must provide the name of the school they are attending and list the expected graduation date.

6. **OTHER INSURANCE (Including Medicare/Medicaid) – You must complete this section if you or any of your dependents are eligible for Medicare, Medicaid or other insurance coverage. If you or any of your dependents have Medicare, please be sure to include a copy of your Medicare card with this application. If you acquire such coverage in the future, you must notify us by completing a new form. If you have more than one person with other insurance, please use a separate sheet of paper to show the additional information.**

STATE OF VERMONT
UNDER AGE 65 RETIREE MEDICAL PLAN OPTIONS
ADD, REMOVE OR CANCEL INSURANCE COVERAGE

ACTION REQUEST: NEW RETIREE | OPEN ENROLLMENT | ADD DEPS. | REMOVE DEPS. | CANCEL COV.
(PLEASE CIRCLE ONE)

RETIREE NAME: (Last, First, MI) _____ **SOC. SEC. NUMBER** _____ **RETIREE ID** _____ **TELEPHONE NUMBERS** _____ WORK _____ HOME

ADDRESS:
Street: _____
City/State/Zip _____ **DATE OF BIRTH:** _____ SEX: M F
( ) Check here if this is a change to your address.

STATUS: ( ) Single ( ) Divorced _____ (Date) ( ) Civil Union _____ (Date)
( ) Married _____ (Date) ( ) Widowed _____ (Date) ( ) Domestic Partner _____ (Date)

CHECK YOUR CHOICE OF MEDICAL PLAN:
( ) TotalChoice Plan ( ) SelectCare POS Plan ( ) HealthGuard PPO Plan ( ) SafetyNet Plan
(If your choice is the SelectCare POS Plan, you must provide the Primary Care Provider's ID number below.)
(The SelectCare POS Plan and the SafetyNet Plan are not available to retirees who are eligible for Medicare.)

CHECK YOUR CHOICE OF COVERAGE:
( ) SINGLE ( ) TWO PERSON ( ) FAMILY (3 or more)

MEMBER INFORMATION: List yourself and all dependents to whom this Action Request applies.
"REL" = Relationship of your dependent to you. Spouse = S, Civil Union Partner = CU, Domestic Partner = DP, Child = C

NAME (Last, First, MI)	BIRTH DATE	SEX	REL	STU	SOC. SEC. NUMBER	SELECTCARE PROV. ID #	CURRENT PATIENT?
		M F	SELF				Y N
		M F					Y N
		M F					Y N
		M F					Y N
		M F					Y N

If your dependent is Age 19 and less than Age 23 and a full-time student, enter a "Y" in the column "STU" above and complete the following:

NAME	NAME OF SCHOOL AND LOCATION	GRADUATION DATE

OTHER INSURANCE INFORMATION If you or any of your dependents are covered by another medical insurance plan (including Medicare and Medicaid), you must complete the following information to assure accurate and timely processing of your claims. If you or any of your dependents are eligible for Medicare, please be sure to include a copy of your Medicare card with this application. If you have more than one person with other insurance, please use a separate sheet of paper to show the additional information.
Insured's Name: _____ Insurance Company Name: _____
Group Number: _____ Policy/Cert Number: _____
Effective Date: _____
Type of Coverage: Single Two Person Family (Circle One)

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 authorize any hospital, physician, pharmacist, dentist, or other health care professional, including other health care insurance or benefit plan, or benefit provider to furnish the health plan with medical information that is pertinent and necessary for payment of claims for myself and my eligible dependents. 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. (If not Medicare eligible, this will not apply to you.) I certify that the above information is complete and that all claims submitted will only be for eligible plan members.

RETIREE SIGNATURE: _____ **DATE SIGNED:** _____

FOR OFFICE USE ONLY:
Insurance Effective Date: _____ Insurance Termination Date: _____ Plan Code: _____
Retirement Date: _____ Branch: _____ Network: _____ Effective Date of Change: _____