

VSTRS Large Group Coverage

Please provide all information and print in ink or type.

Submit one of three ways: email, fax, or mail.
See page 2 for more information.

Enrollment and Change Form for retirees without Medicare coverage

Requested effective date / /

Section 1: EMPLOYER/EMPLOYEE INFORMATION			
Group name: Vermont State Teachers' Retirement System		Plan Selection:	
Group/account no.: 80724 _ _ _		<input type="checkbox"/> J Plan <input type="checkbox"/> Comprehensive <input type="checkbox"/> Vermont Health Partnership (POS)	
Last name:	First name:	Social Security number**** (SSN):	
Mailing address:	City:	State:	ZIP code:
Phone number:	Email address:	Primary Care Physician (PCP) name, or NPI number:	
Date of birth (DOB):	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Marital status: <input type="checkbox"/> Single <input type="checkbox"/> Widowed <input type="checkbox"/> Married/party to a civil union <input type="checkbox"/> Domestic Partner**	Employment status: <input type="checkbox"/> Retired
Are you a current patient? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Health coverage type: <input type="checkbox"/> Employee only <input type="checkbox"/> Employee/spouse (including party to a civil union/domestic partner) <input type="checkbox"/> Employee/child <input type="checkbox"/> Family			

Section 2: NEW ENROLLMENT (Check one, then go to SECTION 4)	
<input type="checkbox"/> Spouse turning age 65 <input type="checkbox"/> Transferred from another BCBSVT plan Transferring from certificate no. _____	

Section 3: CHANGE/CANCELLATION	
Change: Effective date ____/____/____ <input type="checkbox"/> Birth <input type="checkbox"/> Adoption placement date ____/____/____ <input type="checkbox"/> Marriage/Civil Union <input type="checkbox"/> Divorce <input type="checkbox"/> Address change <input type="checkbox"/> Name change <input type="checkbox"/> PCP change <input type="checkbox"/> Court ordered change** <input type="checkbox"/> Loss of coverage**	Cancel: Date of cancellation ____/____/____ <input type="checkbox"/> Voluntary cancel (signature required) _____ <input type="checkbox"/> Left employment (group benefits manager signature) _____ <input type="checkbox"/> Other (explain) _____

Section 4: LIST ALL DEPENDENTS BELOW TO BE ADDED OR REMOVED			
Dependent Information **** Important note: Federal Law mandates our collection of SSN for all members over 45.		Primary Care Physician (PCP) Information (If Managed Care)	
<input type="checkbox"/> Add <input type="checkbox"/> Remove (Spouse/party to a civil union/domestic partner)	SSN****	Gender	PCP Name NPI No.***
Last Name First Name	DOB	<input type="checkbox"/> Male <input type="checkbox"/> Female	Are you a current patient? <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Add <input type="checkbox"/> Remove	SSN****	Gender	PCP Name NPI No.***
Last Name First Name	DOB	<input type="checkbox"/> Male <input type="checkbox"/> Female	Are you a current patient? <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Add <input type="checkbox"/> Remove	SSN****	Gender	PCP Name NPI No.***
Last Name First Name	DOB	<input type="checkbox"/> Male <input type="checkbox"/> Female	Are you a current patient? <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Add <input type="checkbox"/> Remove	SSN****	Gender	PCP Name NPI No.***
Last Name First Name	DOB	<input type="checkbox"/> Male <input type="checkbox"/> Female	Are you a current patient? <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Add <input type="checkbox"/> Remove	SSN****	Gender	PCP Name NPI No.***
Last Name First Name	DOB	<input type="checkbox"/> Male <input type="checkbox"/> Female	Are you a current patient? <input type="checkbox"/> Yes <input type="checkbox"/> No

Please see section 6 on page 2 for subscriber signature

Group name: VSTRS	Employee name:
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Section 5: OTHER INSURANCE INFORMATION

After you obtain health insurance coverage with us, will you or any of your dependents be covered by Medicare? Yes (please complete the applicable section below) No

Section 6: SUBSCRIBER SIGNATURE

I certify that the statements on this application and all information I've furnished is true and complete to the best of my knowledge. I authorize any health care provider to disclose to Blue Cross and Blue Shield of Vermont, or its designated agent, any information acquired in connection with my past or future care or treatment or that of any dependent named herein or hereafter added to my coverage. 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 and Blue Shield of Vermont. I UNDERSTAND THAT MY BENEFITS ARE GOVERNED BY THE PROVISIONS OF MY CERTIFICATE AND OUTLINE OF COVERAGE.

SIGN HERE

▶ Employee's signature _____ date _____ ▲

Mail to:
Vermont State Teachers' Retirement System
109 State Street 4th Floor
Montpelier, VT 05409-6901

If you are adding a dependent child, age 26 or older, contact customer service at (800) 247-2583 for further instructions.

- * = Includes Party to a Civil Union or Domestic partner
- ** = Additional Documentation Required
- *** = See our "Find-a-Doctor" tool at www.bcbsvt.com/findadoctor
- **** = SSN required age 45 and older (Federal mandate requires the collection of SSN)