



**BlueCross BlueShield  
of Vermont**

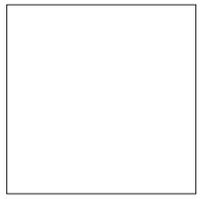
*An Independent Licensee of the  
Blue Cross and Blue Shield Association.*

# Vermont State Teachers' Retirement System Medicare Supplement

## Application and Change Form

Send to Vermont State Teachers' Retirement System • 109 State Street 4th Floor • Montpelier, VT 05609-6901

All information must be provided.  
Please print in ink or type.



### Section 1: Product

Vermont Blue 65       Comp carve out       J carve out

### Section 2: Group Information

**Group Name** Vermont State Teachers' Retirement      **Group No. (including section)** 80724 \_\_\_ \_\_\_

### Section 3: Subscriber Coverage Information (for all transactions)

<b>Name</b>			<b>Social Security No.</b>		
Last Name	First Name	M.I.	<b>Date of Birth</b>		
<b>Home Phone No.</b>			<b>Gender</b> <input type="checkbox"/> Male <input type="checkbox"/> Female		
<b>Physical Address</b>			<b>Mailing Address</b>		
Street Address			Street Address		
City	State	ZIP Code	City	State	ZIP Code
<b>Marital Status</b> <input type="checkbox"/> Single <input type="checkbox"/> Married/Party to a Civil Union			<b>A Photocopy of Your Medicare Card Must Be Enclosed</b>		

### Section 4: Reason for Form (check applicable boxes and indicate dates as mm/dd/yyyy)

<b>Application</b> <input type="checkbox"/> Full Time Hire/Rehire <input type="checkbox"/> Transfer from other BCBS Plan <input type="checkbox"/> Turned 65 Effective Date: ___/___/___	<b>Reason for Change</b> <input type="checkbox"/> Change of Address <input type="checkbox"/> Change of Name <input type="checkbox"/> Other Date of Change: ___/___/___	<b>Cancellation</b> <input type="checkbox"/> Voluntary Cancel <input type="checkbox"/> Obtained Other Coverage <input type="checkbox"/> Retired-transfer to Non-group Coverage <input type="checkbox"/> Death Date of Cancellation: ___/___/___
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### Section 5: Questions

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

<b>Insurance Company</b> (name and address)	<b>Policy Holder Name</b>
<b>Policy No.</b>	<b>Group No.</b>
<b>Effective Date</b>	

**(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

<b>Insurance Company</b> (name and address)	<b>Policy Holder Name</b>
<b>Policy No.</b>	<b>Group No.</b>
<b>Effective Date</b>	

<b>Group Name</b>	<b>Group No.</b> <i>(including section)</i>
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**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 6: Information Required by Law**

- (1) You only need one Medicare supplement policy.
- (2) If you are 65 or older, you may be eligible for benefits under Medicaid and may not need a Medicare supplement policy.
- (3) 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 50 days of becoming eligible for Medicaid. If you are no longer entitled to Medicaid, your policy will be reinstated if requested.
- (4) Counseling services may be available to provide advice concerning your purchase of Medicare supplement insurance and concerning Medicaid.

**Section 7: Signature**

I 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 and Blue Shield of Vermont, or its designated agent, any information acquired in connection with any 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 and Blue Shield of Vermont.

<b>Subscribers Signature</b>	<b>Date</b> ____ / ____ / ____
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<b>FOR OFFICE USE ONLY</b>	<b>Effective Date</b> ____ / ____ / ____	<b>By</b> ____ / ____ / ____
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