BlueCross BlueShield of Vermont

Vermont State Teachers Retirement System (VSTRS)

Enrollment and Change Form for retirees or their dependents with Medicare

With Medicare

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.

Requested effective date ___/___/___

Section 1: Group Information

☐ Vermont Blue 65 (*no pharmacy coverage*) ☐ Comprehensive carve-out ☐ J Plan carve-out

Section 2: Plan Selection

Group Name Vermont State Teachers' Retirement **Group No.** *(including division)* 3160 80724 __ __ __ __ *(for office use)only)*

Section 3: Subscriber Information

Name

Last Name First Name M.I.

Social Security No.

Date of Birth

Home Phone No.

Gender ☐ Male ☐ Female

Physical Address

Street Address

City State ZIP Code

Mailing Address

Street Address

City State ZIP Code

Marital Status ☐ Single ☐ Married/Party to a Civil Union

A Photocopy of Your Medicare Card Must Be Enclosed

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

Enrollment

☐ Open Enrollment
☐ Transfer from other BCBS Plan
☐ Turned 65
☐ Initial Eligibility Period
☐ Loss of Coverage
☐ Other (explain) _____

Effective Date:____/____/_____

Change

☐ Change of Address
☐ Change of Name
☐ Other (explain) _____

Date of Change:____/____/_____

Section 5: Cancellation Only

Cancellation

☐ Voluntary Cancel ☐ Obtained Other Coverage ☐ Death ☐ Other (explain) _____

Date of Cancellation:____/____/_____

I acknowlege I am terminating both my medical and pharmacy (if applicable) benefits. By completing this disenrollment request, I understand I am disenrolling from my Medicare Prescription Drug Plan, Blue MedicareRX℠ (if applicable) through the Vermont Education Health Initiative (VEHI)/Vermont State Teachers' Retirement System (VSTRS) group plan. Additionally, I understand if I have a gap in as Medicare Drug coverage, I may have to pay a penalty in the future. Finally, I understand there are limited times in which I will be able to join other Medicare plans, unless I qualify for a special enrollment period.

Subscriber Signature (required) _____

Group Name	Group No. *(including division)*	Subscriber Name
VSTRS	3160 80724 _ _ _ _ *(for office use only)*	

Section 6: Questions

(1) If you obtain coverage with us, 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

Insurance Company (*name and address*)		**Policy Holder Name**
Policy No.	**Group No.**	**Effective Date**

(2) To the best of your knowledge, do you have any other health insurance policies that provide benefits which the coverage you are applying for would duplicate? If yes, with which company? ☐ Yes ☐ No

Insurance Company (*name and address*)		**Policy Holder Name**
Policy No.	**Group No.**	**Effective Date**

(3) Are you covered by Medicaid? ☐ Yes ☐ No

Section 7: Information Required by Law

(1) You only need one Medicare supplement or Carve-out policy.

(2) You only need one Medicare Prescription Drug Plan (Part D).

(3) If you are 65 or older, you may be eligible for benefits under Medicaid and may not need a Medicare supplement or carve-out policy.

(4) The benefits and premiums under your Medicare supplement carve-out 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 reinstituted if requested.

(5) Counseling services may be available to provide advice concerning your purchase of Medicare supplement insurance and concerning Medicaid.

Section 8: SUBSCRIBER 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 Vermont Education Health Initiative (VEHI)/Vermont State Teachers' Retirement System (VSTRS).
I UNDERSTAND THAT MY BENEFITS ARE GOVERNED BY THE PROVISIONS OF MY BENEFITS DESCRIPTION AND OUTLINE OF COVERAGE.

SIGN HERE

▶Subscriber's signature (required) _____ date _____ ◀

Mail to:
Vermont State Teachers' Retirement System
109 State Street, 4th Floor, Montpelier, VT 05609-6901
Fax to: (802) 828-5182
Email to: TRE.RetirmentBenefitPayroll@vermont.gov

FOR OFFICE USE ONLY	**Effective Date**	**By**
	____ / ____ / ____	____ / ____ / ____

Blue Cross and Blue Shield of Vermont provides administrative services and does not assume any financial risk for claims.

BlueCross BlueShield of Vermont
An Independent Licensee of the Blue Cross and Blue Shield Association.

NOTICE: Discrimination is Against the Law

Blue Cross and Blue Shield of Vermont (BCBSVT) and its affiliate The Vermont Health Plan (TVHP) comply with applicable federal and state civil rights laws and do not discriminate, exclude people or treat them differently on the basis of race, color, national origin, age, disability, gender identity or sex.

BCBSVT provides free aids and services to people with disabilities to communicate effectively with us. We provide, for example, qualified sign language interpreters and written information in other formats (e.g., large print, audio or accessible electronic format).

BCBSVT provides free language services to people whose primary language is not English. We provide, for example, qualified interpreters and information written in other languages.

If you need these services, please call (800) 247-2583. If you would like to file a grievance because you believe that BCBSVT has failed to provide services or discriminated on the basis of race, color, national origin, age, disability, gender identity or sex, contact:

Civil Rights Coordinator
Blue Cross and Blue Shield of Vermont
PO Box 186
Montpelier, VT 05601
(802) 371-3394
TDD/TTY: (800) 535-2227
civilrightscoordinator@bcbsvt.com

You can file a grievance by mail, or email at the contacts above. If you need assistance, our civil rights coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or by mail or phone at:

U.S. Department of
Health and Human Services
Office for Civil Rights
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
(800) 368-1019
(800) 537-7697 (TDD)

For free language-assistance services, call (800) 247-2583.

ARABIC

للحصول على خدمات المساعدة اللغوية المجانية، اتصل على الرقم (800) 247-2583.

CHINESE

如需免費語言協助服務，請致電(800) 247-2583。

CUSHITE (OROMO)

Tajaajila gargaarsa afaan hiikuu kaffaltii malee argachuuf (800) 247-2583 bilbilaa.

FRENCH

Pour obtenir des services d'assistance linguistique gratuits, appelez le (800) 247-2583.

GERMAN

Kostenlose fremdsprachliche Unterstützung erhalten Sie unter (800) 247-2583.

ITALIAN

Per i servizi gratuiti di assistenza linguistica, chiamare il numero (800) 247-2583.

JAPANESE

無料の通訳サービスのご利用は、(800) 247-2583までお電話ください。

NEPALI

निःशुल्क भाषा सहायता सेवाहरूका लागि, (800) 247-2583 मा कल गर्नुहोस्।

PORTUGUESE

Para serviços gratuitos de assistência linguística, ligue para o (800) 247-2583.

RUSSIAN

Чтобы получить бесплатные услуги переводчика, позвоните по телефону (800) 247-2583.

SERBO-CROATIAN (SERBIAN)

Za besplatnu uslugu prevođenja, pozovite na broj (800) 247-2583.

SPANISH

Para servicios gratuitos de asistencia con el idioma, llame al (800) 247-2583.

TAGALOG

Para sa libreng mga serbisyo ng tulong pangwika, tumawag sa (800) 247-2583.

THAI

สำหรับการให้บริการความช่วยเหลือด้านภาษาฟรี โทร (800) 247-2583

VIETNAMESE

Để biết các dịch vụ hỗ trợ ngôn ngữ miễn phí, hãy gọi số (800) 247-2583.

We'll see you through. (800) 255-4550 | www.bcbsvt.com

BlueCross BlueShield of Vermont