BlueCross BlueShield of Vermont

No Medicare

Please provide all information and print in ink or type.

Vermont State Teachers Retirement System (VSTRS)

Enrollment and Change Form for retirees or their dependents without Medicare

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

Requested effective date
/ /

Section 1: GROUP/SUBSCRIBER INFORMATION

Group name: Vermont State Teachers' Retirement System		Plan Selection: ☐ JY Plan ☐ Vermont Health Partnership (POS) ☐ Comprehensive	
Group/division: 3160-80724 __ __ __ __ *(for office use only)*			
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: Are you a current patient? ☐ Yes ☐ No	
Date of birth (DOB):	Gender: ☐ Male ☐ Female	Marital status: ☐ Single ☐ Married/party to a civil union ☐ Domestic Partner**	Health coverage type: ☐ Single ☐ 2-person ☐ Family

Section 2: NEW ENROLLMENT *(Check one, then go to SECTION 4)*

☐ Spouse turning age 65 ☐ Transferred from another BCBSVT plan Transferring from certificate no. ____________________

Section 3: CHANGE/CANCELLATION

Change: *Effective date* ___/___/_____

☐ Open Enrollment
☐ Birth/Adoption placement date ___/___/_____
☐ Marriage/Civil Union
☐ Divorce
☐ Address change
☐ Name change
☐ Court ordered change**
☐ Loss of coverage**

Cancellation: *Date of cancellation* ___/___/_____

☐ Obtained other coverage (*Subscriber signature required*) ____________________
☐ Voluntary cancel (*Subscriber signature required*) ____________________
☐ 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 Provider (PCP) Information *(If POS***)*

Dependent	SSN / DOB	Gender	PCP
☐ Add ☐ Remove *(Spouse/party to a civil union/domestic partner)* Last Name First Name	SSN**** DOB	Gender ☐ Male ☐ Female	PCP Name NPI No.*** Are you a current patient? ☐ Yes ☐ No
☐ Add ☐ Remove Last Name First Name	SSN**** DOB	Gender ☐ Male ☐ Female	PCP Name NPI No.*** Are you a current patient? ☐ Yes ☐ No
☐ Add ☐ Remove Last Name First Name	SSN**** DOB	Gender ☐ Male ☐ Female	PCP Name NPI No.*** Are you a current patient? ☐ Yes ☐ No
☐ Add ☐ Remove Last Name First Name	SSN**** DOB	Gender ☐ Male ☐ Female	PCP Name NPI No.*** Are you a current patient? ☐ Yes ☐ No
☐ Add ☐ Remove Last Name First Name	SSN**** DOB	Gender ☐ Male ☐ Female	PCP Name NPI No.*** Are you a current patient? ☐ Yes ☐ No
☐ Add ☐ Remove Last Name First Name	SSN**** DOB	Gender ☐ Male ☐ Female	PCP Name NPI No.*** Are you a current patient? ☐ Yes ☐ No

Please see section 6 on page 2 for subscriber signature

Group name:	Group no. (including division):	Subscriber name:
VSTRS	80724 _ _ _ *(for office use only)*	

Section 5: OTHER INSURANCE INFORMATION

If you obtain health insurance coverage with us, will you or any of your dependents be covered with another health or dental insurance plan (including Medicare or Medicaid)? ☐ Yes (please complete the applicable section below) ☐ No

MEDICAL	Insurance company (name and address)			DENTAL	Insurance company (name and address)		
	Policyholder name	Policy certificate no.	Group no.		Policyholder name	Policy certificate no.	Group no.
	Effective date	Type of coverage ☐ 1-person ☐ 2-person ☐ Family			Effective date	Type of coverage ☐ 1-person ☐ 2-person ☐ Family	

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

SIGN HERE

▶ Subscriber 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.RetirementBenefitPayroll@vermont.gov

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** to find a pcp.
**** = SSN required age 45 and older (Federal mandate requires the collection of SSN)

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

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

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.