

# Vermont State Teachers Retirement System (VSTRS)

**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.

Enrollment and Change Form for retirees or their dependents with Medicare

 Requested effective date  
 / /

**Section 1: Group Information**
 VSTRS 65 (no pharmacy coverage)

**Section 2: Plan Selection**
**Group Name** Vermont State Teachers' Retirement    **Group No.** (including division) 3 1 6 0 8 0 7 2 4    \_\_ \_\_ \_\_ \_\_ (for office use only)

**Section 3: Subscriber Information**

<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

**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)

<b>Enrollment</b> <input type="checkbox"/> Open Enrollment <input type="checkbox"/> Initial Eligibility Period <input type="checkbox"/> Transfer from other BCBS Plan <input type="checkbox"/> Loss of Coverage <input type="checkbox"/> Turned 65 <input type="checkbox"/> Other (explain) _____ Effective Date: ___/___/___	<b>Change</b> <input type="checkbox"/> Change of Address <input type="checkbox"/> Change of Name <input type="checkbox"/> Other (explain) _____ Date of Change: ___/___/___
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**Section 5: Cancellation Only**
**Cancellation**  
 Voluntary Cancel     Obtained Other Coverage     Death     Other (explain) \_\_\_\_\_  
 Date of Cancellation: \_\_\_/\_\_\_/\_\_\_

I acknowledge 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<sup>SM</sup> (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) \_\_\_\_\_

<b>Group Name</b> VSTRS	<b>Group No. (including division)</b> 3160 80724 _ _ _ _ (for office use only)	<b>Subscriber Name</b>
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### 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

<b>Insurance Company (name and address)</b>	<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 the coverage you are applying for would duplicate? If yes, with which company?  Yes  No

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

(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 reinstated 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.RetirementBenefitPayroll@vermont.gov

<b>FOR OFFICE USE ONLY</b>	<b>Effective Date</b> ____ / ____ / ____	<b>By</b> ____ / ____ / ____
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Blue Cross and Blue Shield of Vermont provides administrative services and does not assume any financial risk for claims.



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