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

☐ VSTRS 65 (*no pharmacy coverage*)

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.RetirementBenefitPayroll@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.

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