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

1-800-247-2583
1-800-535-2227 (TTY)
BCBSVT
P.O. Box 186, Montpelier, VT 05601-0186

First Name:

Last Name:

Date:

ID Number:

SECTION I Do you or a family member have another Health Insurance policy? ▶		**☐ YES ☐ NO**
HEALTH INSURANCE COMPANY INFORMATION: ▼ Name:	NUMBER OF PEOPLE COVERED CHECK ONLY ONE ▼	
Address:	☐ 1. ONE PERSON - POLICYHOLDER	
Phone #:	☐ 2. TWO PERSON – POLICYHOLDER AND SPOUSE/PARTY TO CIVIL UNION	
Policy #:	☐ 3. TWO PERSON – POLICYHOLDER AND CHILD ONLY	
Group #:	☐ 4. FAMILY – THREE OR MORE	
Effective Date:	Policy Holder Name:	

SECTION II Do you or a family member have a Dental Insurance policy? ▶		**☐ YES ☐ NO**
DENTAL INSURANCE COMPANY INFORMATION: ▼ Name:	NUMBER OF PEOPLE COVERED CHECK ONLY ONE ▼	
Address:	☐ 1. ONE PERSON - POLICYHOLDER	
Phone #:	☐ 2. TWO PERSON – POLICYHOLDER AND SPOUSE/PARTY TO CIVIL UNION	
Policy #:	☐ 3. TWO PERSON – POLICYHOLDER AND CHILD ONLY	
Group #:	☐ 4. FAMILY – THREE OR MORE	
Effective Date:	Policy Holder Name:	

SECTION III Do you or a family member have Medicare Insurance? ▶		**☐ YES ☐ NO**
Do you have Medicare part ☐ A ☐ B ☐ D		
MEDICARE INSURANCE INFORMATION: ▼		
Policyholder Name:	Medicare Part A Effective Date:	
Medicare ID #:	Medicare Part B Effective Date:	
	Medicare Part D Effective Date:	

Signature: _____ Date: _____ Phone #: _____

Print Form Please mail the completed questionnaire to:

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