BlueCross BlueShield of Vermont

Please send this form to:
Blue Cross and Blue Shield of Vermont
P.O. Box 186
Montpelier, VT 05601-0186

Vermont Blue 65℠

Enrollment Application & Change Form

☐ Group # _____

☐ Individual

Section 1: Subscriber Coverage Information

Name

First Name Last Name M.I.

Social Security Number

Date of Birth

Medicare Number

Physical Address (required)

Street Address

City State ZIP Code

Email Address

Marital Status

☐ Single ☐ Married/Party to a Civil Union

☐ Widowed ☐ Divorced

Mailing Address (if different)

Street Address

City State ZIP Code

Desired Coverage

☐ Plan A ☐ Plan F**

☐ Plan C** ☐ Plan G

☐ Plan D

Gender

☐ Male

☐ Female

Phone Number

Mobile Phone Number

Employment Status: ☐ Active ☐ Retired

*If you are newly Medicare eligible on or after Jan. 1, 2020—due to changes in federal law, you are no longer eligible to enroll in Plan C or F.

Section 2: Reason for Form

(check applicable boxes and indicate dates as month/day/year)

Application

Effective date _____

☐ Turning/turned 65**

☐ Transfer from other BCBS Plan**

☐ Other—new subscriber

Change

Date of change _____

☐ Name

☐ Address

☐ New disability**

Cancellation

Date of cancellation _____

☐ Voluntary cancel

☐ Obtained other coverage

☐ Death

Section 3: Enrollment & Eligibility

By signing this form, I attest that I do not have other Medicare Supplemental or Medicare Advantage Plan and that when this coverage is in force, I will not have other coverage that would duplicate its benefits.

* If you have just become Medicare eligible or recently retired, you may qualify for our Vermont Medigap Blue℠ Medicare Supplement product. Please call (800) 255-4550 to explore this option.

☐ By signing, I hereby attest that I have read the statements and answered the questions on the back of this form.

Please enclose a check for the first month's premium (made out to Blue Cross and Blue Shield of Vermont).

Subscriber/Authorized Representative's Signature*: _____ **Date:** _____

*If you have been authorized to complete this enrollment form on behalf of the applicant under the laws of the State where that individual resides, you must provide documentation of authority to represent the individual listed on this application.

Section 4: Information Required by Law

Please read these statements.

1. You do not need more than one Medicare Supplement or Medicare Advantage policy.
2. If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverages.
3. You may be eligible for benefits under Medicaid and may not need a Medicare Supplement policy.
4. If, after purchasing this policy, you become eligible for Medicaid, the benefits and premiums under your Medicare Supplement policy can be suspended, if requested, during your entitlement to benefits under Medicaid for 24 months. You must request this suspension within 90 days of becoming eligible for Medicaid. If you are no longer entitled to Medicaid, your suspended Medicare Supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstituted if requested within 90 days of losing Medicaid eligibility. If the Medicare Supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstituted policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.
5. If you are eligible for, and have enrolled in a Medicare Supplement policy by reason of disability and you later become covered by an employer or union-based group health plan, the benefits and premiums under your Medicare Supplement policy can be suspended, if requested, while you are covered under the employer or union-based group health plan. If you suspend your Medicare Supplement policy under these circumstances, and later lose your employer or union-based group health plan, your suspended Medicare Supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstituted if requested within 90 days of losing your employer or union-based group health plan. If the Medicare Supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstituted policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.
6. Counseling services are available through the State of Vermont to provide advice concerning your purchase of Medicare Supplement insurance and concerning medical assistance through the state Medicaid program, including benefits as a Qualified Medicare Beneficiary (QMB), a Specified Low-Income Medicare Beneficiary (SLMB), and the Vermont Health Access Plan (VHAP) pharmacy program.

Please answer these questions. [Please mark Yes or No below with an "X"]

If you lost or are losing other health insurance coverage and received a notice from your prior insurer saying you were eligible for guaranteed issue of a Medicare Supplement insurance policy, or that you had certain rights to buy such a policy, you may be guaranteed acceptance in one or more of our Medicare Supplement plans. Please include a copy of the notice from your prior insurer with your application. Please answer all questions. To the best of your knowledge,

(1) (a) * Did you, or are you about to, turn age 65 or get Medicare Part A in the last 6 months?
Yes ☐ **No** ☐

(b) * Did you enroll in Medicare Part B in the last 6 months?
Yes ☐ **No** ☐

(c) * If yes, what is the effective date? _____

*** You may be eligible for our Vermont Medigap Blue℠ Medicare Supplement product. Please call (800) 255-4550.**

(2) Are you covered for medical assistance through the state Medicaid program?
[Note to applicant: If you are participating in a "Spend-Down Program" and have not met your "Share of Cost," please answer NO to this question.]
Yes ☐ **No** ☐ If yes,

(a) Will Medicaid pay your premiums for this Medicare supplement policy?
Yes ☐ **No** ☐

(b) Do you receive any benefits from Medicaid **other than** payments toward your Medicare Part B premium?
Yes ☐ **No** ☐

(3) (a) If you had coverage from any Medicare plan other than original Medicare within the past 63 days (for example, a Medicare Advantage plan, or a Medicare HMO or PPO), fill in your start and end dates below. If you are still covered under this plan, leave "END" blank. **START** _____ **END** _____

(b) If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare supplement policy?
Yes ☐ **No** ☐

(c) Was this your first time in this type of Medicare plan?
Yes ☐ **No** ☐

(d) Did you drop a Medicare Supplement policy to enroll in the Medicare plan?
Yes ☐ **No** ☐

(4) (a) Do you have another Medicare Supplement policy in force?
Yes ☐ **No** ☐

(b) If so, with what company, and what plan do you have?
_____

(c) If so, do you intend to replace your current Medicare Suplement policy with this policy?
Yes ☐ **No** ☐

(5) Are you currently in the hospital or pending hospital admission? Your coverage is not in effect until 1st of the month following discharge.
Yes ☐ **No** ☐

(6) Have you had coverage under any other health insurance within the past 63 days? (For example, and employer, union, or individual plan)
Yes ☐ **No** ☐

(a) If so, with what company and what kind of policy?
_____

(c) What are your dates of coverage under the other policy?
START_____ **END** _____
(If you are still covered under the other policy, leave "END" blank).

(7) Would you like to cancel your existing Blue Cross VT coverage?
Yes ☐ **No** ☐ **N/A** ☐
[Please note if you are insured through another carrier, please contact them directly to cancel your current plan]

Section 5: How did you hear about us?

How did you hear about us? ☐ Broker ☐ Employer ☐ Agency on Aging ☐ Event: _____

☐ Website ☐ Mail (e.g. postcard, etc.) ☐ Email ☐ Television ☐ Radio ☐ Social media (e.g. Facebook, Twitter)

☐ Print Ad (e.g. magazine, newspaper) ☐ Existing member ☐ Friends & Family ☐ Other: _____