The Vermont Health Plan
An Independent Licensee of the Blue Cross and Blue Shield Association.

Instructions for submitting this enrollment form are provided on page 3.

(800) 255-4550 (TTY/TDD: 711)
bluecrossvt.org/medigapblue

Vermont Medigap Blue℠

Enrollment & Change Form

Section 1: Subscriber Coverage Information

Name:

First Name | Last Name | M.I.

Social Security Number:

Date of Birth:

Medicare Number:

Physical Street Address (required):

City | State | ZIP Code

Desired Coverage:

- ☐ Plan A
- ☐ Plan F*
- ☐ Plan C*
- ☐ Plan G
- ☐ Plan D
- ☐ Plan N

Gender:

- ☐ Male
- ☐ Female

Phone:

Mailing Address:

City | State | ZIP Code

Marital Status:

- ☐ Single
- ☐ Married/Party to a Civil Union
- ☐ Widowed
- ☐ Divorced

Mobile Phone:

Email Address:

*If you became eligible for Medicare before January 1, 2020, you can enroll in Plan C or Plan F.

Section 2: Reason for Form

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

Application:

Effective date: ________________

- ☐ Turning/turned 65
- ☐ New disability
- ☐ Other new subscriber **(please see Section 3 below)**

Change:

Date of change: ____________

- ☐ Name
- ☐ Address

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 Supplement or Medicare Advantage plan and that when this coverage is in force, I will not have other coverage that would duplicate its benefits. I certify that (please check one):

- ☐ I will soon turn 65, will soon retire or I turned 65 years of age within the last six months.
- ☐ I retired in the last 63 days and therefore lost my employer-sponsored health coverage.
  Retirement date: ________________________
- ☐ I involuntarily lost Medicare Supplement or Medicare Advantage coverage within the last 63 days.
  Date of coverage loss: __________________
- ☐ I lost, or will lose, coverage through my spouse/party to a civil union because he or she is retiring.
- ☐ I lost/dropped group coverage
  Date of coverage loss: ________________________
- ☐ I am currently receiving social security disability payments and I became eligible for Medicare within the last six months because I have a total disability.
  Date of Medicare eligibility determination: ____________________________
- ☐ I voluntarily dropped my Medicare Advantage coverage during the 12-month trial period.

☐ By signing, I hereby attest that I have read the statements and answered the questions on the back of this enrollment form. **Please enclose a check for the first month's premium (payable to Blue Cross and Blue Shield of Vermont).**

***Subscriber/Authorized Represenative'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 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? ________________

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 Supplement policy with this policy? **Yes** ☐ **No** ☐

Additional questions on the next page.

5. (a) Have you had coverage under any other health insurance with the past 63 days? (For example: an employer, union, or individual plan).
Yes ☐ **No** ☐
(b) 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).

6. 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** ☐

7. Would you like to cancel your existing Blue Cross and Blue Shield of Vermont 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)
☐ Print ad (e.g. magazine, newspaper) ☐ Existing member ☐ Friends & Family ☐ Other: ______________________

Section 6: Agent/Broker Information (if applicable)

If application is being completed through an agent/broker on your behalf, that individual will receive commissions.
For more information, please contact your agent/broker. The agent/broker must complete this section.

FOR AGENT/BROKER USE ONLY

I, (the agent/broker) certify, I have explained the eligibility provisions to the applicant. I have not made any statements about benefits, conditions or limitations of the contract except through written material furnished by the Plan(s). I have informed the applicant that the effective date of coverage is assigned only by the Plan(s). I have reaffirmed that the information supplied on this application is accurate and complete.

Agent/broker Name (please print or type): First Name Last Name	**Phone Number:** **Email:** **Agent/Broker NPN** (National Producer Number):

Agency name (if applicable):

Commission Code:

SIGN HERE:

▶**Agent/broker's signature (required)** ______________________ **Date (required)** ____________ ◀

AGENT/BROKER: COLLECT NO PREMIUM WITH THIS APPLICATION

Submit one of three ways:

Email:	**Fax:**	**Mail:**
asinbox@bcbsvt.com	(802) 371-3329	Blue Cross and Blue Shield of Vermont P.O. Box 186 Montpelier, VT 05601-0186

The Vermont Health Plan (TVHP) is an independent licensee of the Blue Cross and Blue Shield Association. The Vermont Health Plan is a wholly owned subsidiary of Blue Cross® and Blue Shield® of Vermont. The Vermont Health Plan is not connected with or endorsed by the U.S. government or the Federal Medicare Program. All Medicare Supplement plans are insured by the Vermont Health Plan, a subsidiary of Blue Cross and Blue Shield of Vermont. Insured by The Vermont Health Plan Medicare Supplement plan series Plan A (280.258), Plan C (280.259), Plan D (280.260), Plan F (280.300), Plan G (280.507), Plan N (208.299).

Disclaimers

General Exclusions

A Medicare Supplement plan provides coverage designed to coordinate with your federal Medicare coverage. To fully understand a Medicare Supplement plan, you should read it alongside the Medicare Handbook, Medicare and You. We will provide Benefits as if you are enrolled in both Part A and Part B of Original Medicare and as if Medicare has paid its portion. You can find the Medicare and You handbook by visiting **Medicare.gov/Medicare-and-you**. Once you enroll, you will receive a Certificate of Coverage. Please read both carefully as they govern your specific benefits.

How We Protect Your Privacy

The law requires us to maintain the privacy of your health information by using or disclosing it only with your authorization or as otherwise allowed by law. You may find information about our privacy practices at **bluecrossvt.org/privacypolicies**.

NOTICE: Discrimination is Against the Law

BlueCross® and BlueShield® of Vermont (Blue Cross VT) 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, ethnicity, sexual orientation, or HIV-status.

Blue Cross VT 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).

Blue Cross VT 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, contact Whitney Standefer-Smith, **civilrightscoordinator@bcbsvt.com**

If you believe that Blue Cross VT has failed to provide these services or discriminated in another way based on race, color, national origin, age, disability, gender identity or sex, ethnicity, sexual orientation, or HIV-Status, you can file a grievance with: Whitney Standefer-Smith, Civil Rights Coordinator, P.O. Box 186, Montpelier, VT 05601-0186, call (800) 247-2583 (TTY/TDD: 711), fax (802) 229-0511, or email **civilrightscoordinator@bcbsvt.com**. You can file a grievance in person, by mail, via fax, or by email. If you need help filing a grievance, the 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 or 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
200 Independence Avenue, SW Room 509F,
HHH Building Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at
https://www.hhs.gov/ocr/complaints/index.html

For free language-assistance services, call (800) 247-2583 (TTY/TDD: 711).

ARABIC	للحصول على خدمات المساعدة اللغوية المجانية ، اتصل (800) 247 2583 (TTY/TTD: 711). lilhusul ealaa khadmat almusaeadat allughawiat almajaaniat, atasal (800) 247-2583 (TTY/TDD: 711).
CHINESE	如需免费语言协助服务，请致电, (800) 247-2583 (TTY/TDD: 711). Rú xū miǎnfèi yǔyán xiézhù fúwù, qǐng zhìdiàn (800) 247-2583 TTY/TDD: 711).
CUSHITE (OROMO)	Tajaajila gargaarsa afaanii bilisaa argachuuf, (800) 247-2583 (TTY/TDD: 711) bilbili.
FRENCH	Pour des services d'assistance linguistique gratuits, appelez le (800) 247-2583 (TTY/TDD: 711).
GERMAN	Für kostenlose Sprachunterstützungsdienste rufen Sie (800) 247-2583 (TTY/TDD: 711) an.
ITALIAN	Per i servizi di assistenza linguistica gratuiti, chiamare il numero (800) 247-2583 (TTY/TDD: 711).
JAPANESE	無料の言語支援サービスについては, (800) 247-2583 (TTY/TDD: 711). Muryō no gengo shien sābisu ni tsuite wa, (800) 247-2583 (TTY/TDD: 711) made o denwa kudasai.
NEPALI	निःशुल्क भाषा-सहायता सेवाहरूको लागि, कल गर्नुहोस् , (800) 247-2583 (TTY/TDD: 711). Niḥśulka bhāṣā-sahāyatā sēvāharūkō lāgi, kala garnuhōs (800) 247-2583 (TTY/TDD: 711).
PORTUGUESE	Para serviços gratuitos de assistência linguística, ligue para (800) 247-2583 TTY/TDD: 711).
RUSSIAN	Чтобы получить бесплатную языковую помощь, позвоните по телефону (800) 247-2583 (TTY/TDD: 711).
SERBO-CROATIAN (SERBIAN)	За бесплатне услуге језичке помоћи позовите (800) 247-2583 (TTY/TTD: 711). Za besplatne usluge jezičke pomoći pozovite (800) 247-2583 (TTY/TDD: 711).
SPANISH	Para servicios gratuitos de asistencia lingüística, llame al (800) 247-2583 (TTY/TDD: 711).
TAGALOG	PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa (800) 247-2583 (TTY/TDD: 711).
THAI	สำหรับบริการช่วยเหลือด้านภาษาฟรี โทร, (800) 247-2583 (TTY/TDD: 711). S̄ảh̄rạb brikār ch̀wyh̄elụ̄x d̂ān phās̄'ā frī thor (800) 247-2583 (TTY/TDD: 711).
UKRAINIAN	Щоб отримати безкоштовні мовні послуги, телефонуйте (800) 247-2583 (TTY/TDD: 711). Shchob otrymaty bezkoshtovni movni posluhy, telefonuyte (800) 247-2583 (TTY/TDD: 711)
VIETNAMESE	Đối với các dịch vụ hỗ trợ ngôn ngữ miễn phí, hãy gọi (800) 247-2583 (TTY/TDD: 711).