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

Instructions for submitting this application are provided on page 4.

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

Vermont Medigap Blue℠

Medicare Supplement Application & Change Form

Section 1: Subscriber Information

Name: First Name Last Name Middle Initial	**Social Security Number:**	**Date of Birth:**
	Medicare Number:	
Physical Address (required)**:**	**Marital Status:** ☐ Single ☐ Married ☐ Widowed ☐ Divorced	**Gender:** ☐ Male ☐ Female
City State ZIP Code	**Phone Number*:**	
Mailing Address (if different)**:**	**Cell Phone Number*:**	
City State ZIP Code	**Email*:**	

*By providing my contact information (phone or email), I understand Blue Cross VT may communicate with me about my submitted enrollment form.

Section 2: Policy Selection/Change

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

Desired Coverage:

☐ Plan A ☐ Plan F*
☐ Plan C* ☐ Plan G
☐ Plan D ☐ High Deductible Plan G
☐ Plan N

New Application:

Desired effective date:

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

Change:

Date of change:

☐ Name
☐ Address
☐ Policy

Termination:

Date of cancel:

☐ Voluntary cancel
☐ Obtained other coverage
☐ Death

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

Section 3: Reason for Application

By signing this application, I attest, that I do not have other Medicare Supplement coverage or a 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.

Section 4: Important Statements

Please read these statements.

1. You do not need more than one Medicare Supplement policy or Medicare Advantage plan.
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 such as the Qualified Medicare Beneficiary (QMB) and Vermont's Prescription Assistance programs under Vermont's Department of Financial Regulation Medicare Supplement Insurance Minimum Standards Rule H-2009-04 (amended as of August 15, 2019).

Section 5: Existing Coverage Questions

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? _____

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 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** ☐

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 6: Subscriber Signature

☐ 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 application 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 7: How Did You Hear About Us?

How did you hear about us?

☐ Agent/Broker ☐ Employer ☐ Agency on Aging ☐ Event: _____ ☐ Blue Cross VT Website
☐ Other Website ☐ Mailer (e.g. postcard or letter etc.) ☐ Social media (e.g. Facebook) ☐ Former Member
☐ Current member ☐ Friends & Family ☐ Other: _____

Section 8: Agent/Broker Information (if applicable)

If this 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: First Name Last Name	**Phone Number:**
	Email:
	Agent/Broker NPN (National Producer Number)**:**

Agency Name (if applicable):

Commission Code:

SIGN HERE:

▶**Agent/Broker Signature (required):** _____ **Date (required):** _____ ◀

AGENT/BROKER: DO NOT COLLECT PREMIUM AT TIME OF THIS APPLICATION SUBMISSION

We will mail an invoice to the applicant.

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 Medicare Supplement plan series. For Aged 65: Plan A (280.258), Plan C (280.259), Plan D (280.260), Plan F (280.300), Plan G (280.507), High Deductible Plan G (280.616), Plan N (280.299). For Disabled: Plan A (280.521), Plan C (280.524), Plan D (280.527), Plan F (280.530), Plan G (280.533), High Deductible Plan G (280.617), Plan N (280.536).

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 who speak or sign languages other than English. We provide, for example, qualified interpreters and information written in other languages.

If you need these services, **contact the Civil Rights Coordinator at 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: 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 service, call (800) 247-2583 (TTY/TDD: 711).

ARABIC العربية	للحصول على خدمة المساعدة اللغوية المجانية، اتصل على الرقم (800) 247-2583 (TTY/TDD: 711). lilhusul ealaa khadmat almusaeadat allughawiat almajaaniat, atasal (800) 247-2583 (TTY/TDD: 711).
BOSNIAN BOSANSKI	Za besplatnu uslugu jezičke pomoći nazovite (800) 247-2583 (TTY/TDD: 711).
BURMESE မြန်မာဘာသာ	အခမဲ့ ဘာသာစကားအကူအညီ ဝန်ဆောင်မှုအတွက် (800) 247-2583 (TTY/TDD: 711) သို့ ဖုန်းခေါ်ပါ။
DARI دری	د وړیا ژبنی مرستې خدماتو لپاره، له (800) 247-2583 (TTY/TDD: 711) شمیرې سره اړیکه ونیسئ
FRENCH FRANÇAIS	Pour des services d'assistance linguistique gratuits, appelez le (800) 247-2583 (TTY/ TDD: 711).
KIRUNDI IKIRUNDI	Niba ukeneye ubwunganizi mu ndimi ku buntu, hamagara kuri (800) 247-2583 (TTY/TDD: 711).
NEPALI नेपाली	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).
PASHTO پښتو	برای خدمات رایگان کمک زبانی، با شماره تماس (800) 247-2583 (TTY/TDD: 711) بگیرید
SIMPLIFIED CHINESE 简体中文	如需免费语言协助服务，请拨打 (800) 247-2583 (TTY/TDD: 711)。
SOMALI SOOMAALI	Si aad u hesho adeeg caawimo luuqadeed ah oo bilaash ah, wac (800) 247-2583 (TTY/TDD: 711).
SPANISH ESPAÑOL	Para servicios gratuitos de asistencia lingüística, llame al (800) 247-2583 (TTY/TDD: 711).
SWAHILI KISWAHILI	Kwa huduma ya usaidizi wa lugha bila malipo, piga simu kwa (800) 247-2583 (TTY/TDD: 711).
THAI ไทย	สำหรับบริการช่วยเหลือด้านภาษาฟรี โทร, (800) 247-2583 (TTY/TDD: 711). S̄âh̄rạb brikār ch̀wyh̄elp̄x d̂ān phās'ā frī thor (800) 247-2583 (TTY/TDD: 711).
UKRAINIAN УКРАЇНСЬКА МОВА	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 TIẾNG VIỆT	Đối với các dịch vụ hỗ trợ ngôn ngữ miễn phí, hãy gọi (800) 247-2583 (TTY/TDD: 711).