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

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

Vermont Medigap Blue℠

Enrollment Application & Change Form

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

Desired Coverage:

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

Gender:

☐ Male ☐ Female

Phone:

Mailing Address:

Street Address:

City State ZIP Code

Marital Status:

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

Mobile Phone:

Email Address:

* 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
☐ 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 Coverage 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 form. **Please enclose a check for the first month's premium (from a non-business account made out 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):	**Phone Number:**
	Email:
First Name Last Name	**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