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

Return this form to:
Blue Cross Blue Shield of VT
P.O. BOX 186
MONTPELIER, VT 05601-0186

1-800-272-3684

NON-GROUP MEDICARE SUPPLEMENT Application and Change Form

All Information Must Be Provided, Please Print In Ink or Type

A PHOTOCOPY OF YOUR MEDICARE CARD MUST BE ENCLOSED

SECTION 1: SUBSCRIBER COVERAGE INFORMATION (FOR ALL TRANSACTIONS)

NAME (LAST, FIRST, INITIAL)		SOCIAL SECURITY NO.	DATE OF BIRTH
PHYSICAL ADDRESS	CITY, STATE, ZIP CODE	DESIRED COVERAGE ☐ MEDI-COMP PLAN A ☐ MEDI-COMP PLAN C	HOME PHONE NO.
MAILING ADDRESS	CITY, STATE, ZIP CODE	MARITAL STATUS ☐ MARRIED/PARTY TO A CIVIL UNION ☐ SINGLE ☐ DIVORCED ☐ WIDOWED	GENDER ☐ MALE ☐ FEMALE

SECTION 2: REASON FOR FORM (check applicable boxes and indicate dates as M/D/Y)

APPLICATION
- ☐ Turned 65
- ☐ Transfer from other BCBS Plan
- ☐ New Subscriber

CHANGE:
- ☐ Disability
- ☐ Address
- ☐ Name

Date of Event / /

CANCELLATION
- ☐ Voluntary Cancel
- ☐ Obtained Other Coverage
- ☐ Death

Date of Event / /

SECTION 3: EMPLOYER INFORMATION

SUBSCRIBER	SPOUSE/PARTY TO A CIVIL UNION
☐ EMPLOYED ☐ SELF EMPLOYED ☐ UNEMPLOYED ☐ RETIRED	☐ EMPLOYED ☐ SELF EMPLOYED ☐ UNEMPLOYED ☐ RETIRED
EMPLOYER NAME AND ADDRESS IF EMPLOYED	EMPLOYER NAME AND ADDRESS IF EMPLOYED
IS THERE A GROUP INSURANCE PLAN OFFERED AT YOUR PLACE OF EMPLOYMENT? IF YES STATE WHY YOU ARE NOT COVERED. ☐ YES ☐ NO	IS THERE A GROUP INSURANCE PLAN OFFERED AT YOUR PLACE OF EMPLOYMENT? IF YES STATE WHY YOU ARE NOT COVERED. ☐ YES ☐ NO
SUBSCRIBER DAYTIME PHONE NO.	SPOUSE/PARTY TO A CIVIL UNION DAY-TIME PHONE NO.

SECTION 4: QUESTIONS

(1) To the best of your knowledge, do you have another Medicare supplement policy or certificate in force (including health care service contract, health maintenance organization (HMO) contract)? If yes, with which company? ☐ Yes ☐ No

INSURANCE COMPANY (NAME AND ADDRESS)		POLICY HOLDER NAME
POLICY NO.	GROUP NO.	EFFECTIVE DATE / /

(2) To the best of your knowledge, do you have any other health insurance policies that provide benefits which this Medicare supplement policy would duplicate? If yes, with which company? ☐ Yes ☐ No

INSURANCE COMPANY (NAME AND ADDRESS)		POLICY HOLDER NAME
POLICY NO.	GROUP NO.	EFFECTIVE DATE / /

What kind of policy?

(3) If the answer to question 1 or 2 is yes, do you intend to replace these medical or health policies with this policy? ☐ Yes ☐ No

(4) Are you covered by Medicaid? ☐ Yes ☐ No

SECTION 5: STATEMENTS

(1) You do not need more than one Medicare supplement policy.

(2) If you are 65 or older, you may be eligible for benefits under Medicaid and may not need a Medicare supplement policy.

(3) The benefits and premiums under your Medicare supplement policy will be suspended 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 policy will be reinstituted if requested within 90 days of losing Medicaid eligibility.

(4) Counselling services may be available to provide advice concerning your purchase of Medicare supplement insurance and concerning Medicaid.

SECTION 6: SIGNATURE

I certify that the statements on this application and all information furnished by me are true and complete to the best of my knowledge. I authorize any health care provider to disclose to Blue Cross Blue Shield of Vermont, or its designated agent, any information acquired in connection with my past or future care or treatment. I understand that no right whatsoever is created by this application and that the same shall not be considered accepted unless and until the contract is actually issued by Blue Cross Blue Shield of Vermont.

SUBSCRIBER'S SIGNATURE	DATE / /	FOR OFFICE USE ONLY	EFFECTIVE DATE / /	BY / /

2430.07 (4/03)

SEND ORIGINAL AND PINK COPY TO: BLUE CROSS BLUE SHIELD OF VERMONT

ORIGINAL