

# GROUP SUBSCRIBER MEDICARE SUPPLEMENT APPLICATION AND CHANGE FORM

All Information Must be  
Provided, Please Print in  
Ink or Type

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

SECTION 1: GROUP INFORMATION		
GROUP NO. - SECTION	DATE OF HIRE	EMPLOYMENT STATUS <input type="checkbox"/> ACTIVE <input type="checkbox"/> RETIRED
GROUP NAME	PROBATIONARY PERIOD <span style="float: right;">DAYS</span>	

**A PHOTOCOPY OF YOUR MEDICARE CARD MUST BE ENCLOSED**

## SECTION 2: SUBSCRIBER COVERAGE INFORMATION (FOR ALL TRANSACTIONS)

NAME (LAST, FIRST, INITIAL)	SOCIAL SECURITY NO.	DATE OF BIRTH
STREET ADDRESS	HOME PHONE NO.	SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
CITY, STATE, ZIP CODE	MARITAL STATUS <input type="checkbox"/> MARRIED/PARTY TO A CIVIL UNION <input type="checkbox"/> SINGLE <input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED	

## SECTION 3: REASON FOR FORM (check applicable boxes and indicate dates as M/D/Y)

<b>REASON FOR CHANGE:</b> <input type="checkbox"/> Change of Address <input type="checkbox"/> Change of Name <input type="checkbox"/> Other	<b>APPLICATION</b> <input type="checkbox"/> Full Time Hire/Rehire <input type="checkbox"/> Transfer from other BCBS Plan <input type="checkbox"/> Turned 65	Date of Event / /	<b>CANCELLATION</b> <input type="checkbox"/> Voluntary Cancel <input type="checkbox"/> Obtained Other Coverage <input type="checkbox"/> Retired - Transfer to Nongroup Coverage <input type="checkbox"/> Death	Date of Event / /
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## 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 reinstated if requested within 90 days of losing Medicaid eligibility.
- (4) Counseling 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 / /	<b>FOR OFFICE USE ONLY</b>	EFFECTIVE DATE / /	BY / /
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