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

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

VermontBlue 65℠
Application and Change Form

☐ **Group #**_____
☐ **Individual**

Section 1: Subscriber Coverage Information

Name
Last Name First Name M.I.

Social Security No.

Date of Birth

Cell Phone

Home Phone No.

Physical Address (required)
Street Address
City State ZIP Code

Desired Coverage
☐ Plan A
☐ Plan C

Effective Date

Mailing Address (if different)
Street Address
City State ZIP Code

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

Gender
☐ Male
☐ Female

E-mail Address

Employment Status: ☐ Active ☐ Retired

Section 2: Reason for Form *(check applicable boxes and indicate dates as month/day/year)*

Application
☐ Turning/turned 65*
☐ Transfer from other BCBS Plan*
☐ Other—new subscriber
Date of the above ___/___/___

Change
☐ Name
☐ Address
☐ New disability*
Date of change ___/___/___

Cancellation
☐ Voluntary cancel
☐ Obtained other coverage
☐ Death
Date of cancellation ___/___/___

Section 3: Enrollment & Eligibility

By signing this form, I attest that I do not have other Medicare Supplemental Coverage and that when this coverage is in force, I will not have other coverage that would duplicate its benefits.

☐ Date of retirement: _____

* If you have just retired or just turned 65, you may qualify for our Vermont Medigap Blue supplemental product. Please call (802) 371-3299 to explore this option.

☐ 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 (made out to Blue Cross and Blue Shield of Vermont) and a copy of your Medicare card.

Subscriber's Signature: _____ Date: ___ /____ /_____

Be sure to read the information on the back of this form and answer the questions that follow.

Section 4: Information Required by Law

Please read these statements.

1. You do not need more than one Medicare supplement 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.

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.***

[Please mark Yes or No below with an "X"]

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? _____

* **You may be eligible for our Vermont Medigap Blue supplemental product. Please call Jill at (802) 371-3299.**

(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** ☐