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℠

Application and Change Form

Vermont Medigap Blue℠

Section 1: Subscriber Coverage Information

Name

Last Name First 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

Email Address

Home Phone No.

Mailing Address

Street Address

City State ZIP Code

Marital Status

☐ Single
☐ Married/ Party to a Civil Union

Daytime Phone No.

Sex

☐ Male ☐ Female

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

Application

Please provide copy of your Medicare Card

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 Supplemental Coverage 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-supplemental 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) **and a copy of your Medicare card.**

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

* If you are newly Medicare eligible on or after January 1, 2020—you are no longer eligible to enroll in Plans C or F.

Code: _____

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) Do you have another Medicare supplement policy in force? **Yes** ☐ **No** ☐

(5) Are you currently in the hospital or pending hospital admission? **Yes** ☐ **No** ☐

(6) Would you like to cancel your existing BCBSVT coverage? **Yes** ☐ **No** ☐

[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 ☐ Email ☐ Employer ☐ Event: _____
☐ Google/search engine ☐ Mail (e.g. postcard, etc.) ☐ Print ad (e.g. magazine, newspaper) ☐ Radio ☐ Current member
☐ Social media (e.g. Facebook, Twitter) ☐ Television ☐ Web ☐ Word of mouth ☐ Other: _____

Section 6: Agent/Broker Information *(if applicable)*

If application is being made through an agent/broker on your behalf, that individual will receive commissions. As a result, using an agent/broker results in higher rates. For more information, please contact your agent/broker. He or she 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 BCBSVT. I have informed the applicant that the effective date of coverage is assigned only by BCBSVT. I have reaffirmed that the information supplied on this application is accurate and complete.

Agent/broker Name *(please print or type)*

Last Name First Name M.I.

Phone Number:

Agent/Broker Number:

Agency name *(if applicable)*

SIGN HERE

▶ Agent/broker's signature *(required)* _____ date *(required)* _____ ◀

AGENT/BROKER: COLLECT NO PREMIUM WITH THIS APPLICATION

Code: _____

NOTICE: Discrimination is against the law

Blue Cross and Blue Shield of Vermont (BCBSVT) 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.

BCBSVT 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).

BCBSVT provides free language services to people whose primary language is not English. We provide, for example, qualified interpreters and information written in other languages.

If you need these services, please call (800) 247-2583. If you would like to file a grievance because you believe that BCBSVT has failed to provide services or discriminated on the basis of race, color, national origin, age, disability, gender identity or sex, contact:

Civil Rights Coordinator
Blue Cross and Blue Shield of Vermont
PO Box 186
Montpelier, VT 05601
(802) 371-3394
TDD/TTY: (800) 535-2227
civilrightscoordinator@bcbsvt.com

You can file a grievance by mail, or email at the contacts above. If you need assistance, our 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 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
Office for Civil Rights
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
(800) 368-1019
(800) 537-7697 (TDD)

For free language-assistance services, call (800) 247-2583.

ARABIC

للحصول على خدمات المساعدة اللغوية المجانية، اتصل على الرقم (800) 247-2583.

CHINESE

如需免費語言協助服務，請致電(800) 247-2583。

CUSHITE (OROMO)

Tajaajila gargaarsa afaan hiikuu kaffaltii malee argachuuf (800) 247-2583 bilbilaa.

FRENCH

Pour obtenir des services d'assistance linguistique gratuits, appelez le (800) 247-2583.

GERMAN

Kostenlose fremdsprachliche Unterstützung erhalten Sie unter (800) 247-2583.

ITALIAN

Per i servizi gratuiti di assistenza linguistica, chiamare il numero (800) 247-2583.

JAPANESE

無料の通訳サービスのご利用は、(800) 247-2583までお電話ください。

NEPALI

निःशुल्क भाषा सहायता सेवाहरूका लागि, (800) 247-2583 मा कल गर्नुहोस्।

PORTUGUESE

Para serviços gratuitos de assistência linguística, ligue para o (800) 247-2583.

RUSSIAN

Чтобы получить бесплатные услуги переводчика, позвоните по телефону (800) 247-2583.

SERBO-CROATIAN (SERBIAN)

Za besplatnu uslugu prevođenja, pozovite na broj (800) 247-2583.

SPANISH

Para servicios gratuitos de asistencia con el idioma, llame al (800) 247-2583.

TAGALOG

Para sa libreng mga serbisyo ng tulong pangwika, tumawag sa (800) 247-2583.

THAI

สำหรับการให้บริการความช่วยเหลือด้านภาษาฟรี โทร (800) 247-2583

VIETNAMESE

Để biết các dịch vụ hỗ trợ ngôn ngữ miễn phí, hãy gọi số (800) 247-2583.