BlueCross BlueShield of Vermont

No Medicare

Please provide all information and print in ink or type.

Vermont State Teachers Retirement System (VSTRS)

Enrollment and Change Form for retirees or their dependents without Medicare

Submit one of three ways: email, fax, or mail.
See page 2 for more information.

Requested effective date / /

Section 1: GROUP/SUBSCRIBER INFORMATION

Group name: Vermont State Teachers' Retirement System		Plan Selection: ☐ JY ☐ Vermont Health Partnership (POS) ☐ Comprehensive	
Group/division: 3160-80724 __ __ __ __ *(for office use only)*			
Last name:	First name:	Social Security number**** (SSN):	
Mailing address:	City:	State:	ZIP code:
Physical address:	City:	State::	ZIP code
Phone number:	Email address:	Primary Care Physician (PCP) name, or NPI number: Are you a current patient? ☐ Yes ☐ No	
Date of birth (DOB): / Gender: ☐ Male ☐ Female	Marital status: ☐ Single ☐ Married/party to a civil union ☐ Domestic Partner**	Health coverage type: ☐ Single ☐ 2-person ☐ Family	

Section 2: NEW ENROLLMENT *(Check one, then go to SECTION 4)*

☐ Spouse turning age 65 ☐ Transferred from another BCBSVT plan Transferring from certificate no. ____________

Section 3: CHANGE/CANCELLATION

Change: *Effective date* ___/___/_____

☐ Open Enrollment
☐ Birth/Adoption placement date ___/___/_____
☐ Marriage/Civil Union
☐ Divorce
☐ Address change
☐ Name change
☐ Court ordered change**
☐ Loss of coverage**

Cancellation: *Date of cancellation* ___/___/_____

☐ Obtained other coverage (*Subscriber signature required*) ____________
☐ Voluntary cancel (*Subscriber signature required*) ____________
☐ Other (explain) ____________

Section 4: LIST ALL DEPENDENTS BELOW TO BE ADDED OR REMOVED

Dependent Information **** Important note: Federal Law mandates our collection of SSN for all members over 45.

Primary Care Provider (PCP) Information *(If POS***)*

Dependent	SSN / DOB	Gender	PCP
☐ Add ☐ Remove *(Spouse/party to a civil union/domestic partner)* Last Name First Name	SSN**** DOB	Gender ☐ Male ☐ Female	PCP Name NPI No.*** Are you a current patient? ☐ Yes ☐ No
☐ Add ☐ Remove Last Name First Name	SSN**** DOB	Gender ☐ Male ☐ Female	PCP Name NPI No.*** Are you a current patient? ☐ Yes ☐ No
☐ Add ☐ Remove Last Name First Name	SSN**** DOB	Gender ☐ Male ☐ Female	PCP Name NPI No.*** Are you a current patient? ☐ Yes ☐ No
☐ Add ☐ Remove Last Name First Name	SSN**** DOB	Gender ☐ Male ☐ Female	PCP Name NPI No.*** Are you a current patient? ☐ Yes ☐ No
☐ Add ☐ Remove Last Name First Name	SSN**** DOB	Gender ☐ Male ☐ Female	PCP Name NPI No.*** Are you a current patient? ☐ Yes ☐ No
☐ Add ☐ Remove Last Name First Name	SSN**** DOB	Gender ☐ Male ☐ Female	PCP Name NPI No.*** Are you a current patient? ☐ Yes ☐ No

Please see section 6 on page 2 for subscriber signature

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Group name: VSTRS	Group no. (including division): 80724 _ _ _ *(for office use only)*	Subscriber name:

Section 5: OTHER INSURANCE INFORMATION

If you obtain health insurance coverage with us, will you or any of your dependents be covered with another health or dental insurance plan (including Medicare or Medicaid)? ☐ Yes (please complete the applicable section below) ☐ No

MEDICAL			DENTAL		
Insurance company (name and address)			Insurance company (name and address)		
Policyholder name	Policy certificate no.	Group no.	Policyholder name	Policy certificate no.	Group no.
Effective date	Type of coverage ☐ 1-person ☐ 2-person ☐ Family		Effective date	Type of coverage ☐ 1-person ☐ 2-person ☐ Family	

Section 6: SUBSCRIBER SIGNATURE

I certify that the statements on this application and all information I've furnished is true and complete to the best of my knowledge. I authorize any health care provider to disclose to Blue Cross and Blue Shield of Vermont, or its designated agent, any information acquired in connection with my past or future care or treatment or that of any dependent named herein or hereafter added to my coverage. 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 Vermont Education Health Initiative (VEHI)/Vermont State Teachers' Retirement System (VSTRS).
I UNDERSTAND THAT MY BENEFITS ARE GOVERNED BY THE PROVISIONS OF MY BENEFITS DESCRIPTION AND OUTLINE OF COVERAGE.

SIGN HERE

▶ Subscriber signature (required) ______________________________ date ______________ ◀

Mail to:
Vermont State Teachers' Retirement System
109 State Street, 4th Floor, Montpelier, VT 05609-6901
Fax to: (802) 828-5182
Email to: TRE.RetirementBenefitPayroll@vermont.gov

If you are adding a dependent child, age 26 or older, contact customer service at (800) 247-2583 for further instructions.

* = Includes Party to a Civil Union or Domestic partner
** = Additional Documentation Required
*** = See our "Find-a-Doctor" tool at **www.bcbsvt.com/findadoctor** to find a pcp.
**** = SSN required age 45 and older (Federal mandate requires the collection of SSN)

Blue Cross and Blue Shield of Vermont provides administrative services and does not assume any financial risk for claims.

FOR OFFICE USE ONLY	**Effective Date** ____ / ____ / ____	**By** ____ / ____ / ____

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