Opt-Out Form Instructions
Vermont Blue Advantage Group[SM] PPO

The University of Vermont has decided to replace your current retiree medical and pharmacy coverage plan with a Vermont Blue Advantage Group PPO plan.

You will be automatically enrolled in the Vermont Blue Advantage Group PPO plan unless you notify us that you **do not** wish to be enrolled by returning this form.

- If you **do not want** to retain coverage under the University of Vermont Medicare Advantage health care plan, you can opt out by completing this form, signing it, and sending it to the address below.
- If you **do want** Vermont Blue Advantage Group PPO coverage, **do not return this form**. Only return this form if you do not want to be covered by the Medicare Advantage plan offered through the University of Vermont.

Important

- Declining Vermont Blue Advantage Group PPO coverage may affect other coverage your employer or union group offers. Before submitting this form, contact your employer or union group to find out what will happen to those benefits if you decline Medicare Advantage coverage.
- Vermont Blue Advantage may contact you for verification of your coverage opt-out selection. Please make sure **you provide your current phone number** on the attached form underneath your signature.
- Return the form to:
  Email: HRinfo@UVM.edu

  or

  Mail:
  University of Vermont Human Resource Services
  Waterman 228
  85 South Prospect Street
  Burlington, VT 05405

  For questions about this form, please call 1-802-656-3150.

Opt-Out Form
Vermont Blue Advantage Group PPO

If you wish to decline coverage, complete all sections below and return. Please print.

Name of contract holder (retiree, spouse, or domestic partner)	
Date of birth	Medicare ID number

Important: You can only be enrolled in one Medicare Advantage plan at a time. If you are already enrolled in an individual Medicare Advantage plan or an individual Medicare prescription drug plan, or if you are covered through your spouse's Medicare Advantage or prescription drug plan, you must decide which plan you wish to keep. If you do not use this form to notify us that you are enrolled in another plan, we will enroll you in the University of Vermont Medicare Advantage plan and Medicare will automatically cancel your other Medicare health plan or Medicare prescription drug plan coverage.

❑ I decline Medicare Advantage coverage for myself and understand this will result in cancellation of all health benefits covered by the University of Vermont.

Once you or your representative have checked one box above and provided any requested information, please complete the information below, sign, and date.

X_____ _____

Contract holder's signature Date

(_____)_____

Daytime phone number

If you are signing as the contract holder's authorized representative, complete the section below.

The following is authorized to act on behalf of the individual above under the laws of the State in which the individual resides. If signed by an authorized individual, this signature certifies that 1) this person is authorized under State law to complete this opt-out form and 2) documentation of this authority is available upon request.

Name of representative	Daytime phone number
Address	Relationship to retiree

For office use only

Received date		Confirm date		Group representative name	
Please check one	❑ Opt-out confirmed ❑ Opt-out reversed (Member will be enrolled)				
Comments					