Enrollment Request for Vermont Blue Advantage Group[SM] PPO

Please contact Vermont Blue Advantage Group PPO if you need information in another language or format.

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

For internal use only	
Received date	Effective date

To enroll in Vermont Blue Advantage Group PPO, please provide the following information.	
Employer or union name	Group #

Please provide the following information in print

First name	Middle initial	Last name

Birth date (mm/dd/yyyy)	Sex ☐ Male ☐ Female	Phone number (optional)	Alternate phone number (optional)

Permanent residence street address (Don't enter a PO Box. Note: For individuals experiencing homelessness, a PO Box may be considered your permanent residence address.)

City	State

ZIP code	County (optional)	Email address (optional)

Mailing address (*only if different from your permanent residence address*)

Street address	City	State	ZIP code

Optional information

Emergency contact name	
Relationship to you	Phone number

Please provide your Medicare insurance information

Please take out your **red, white and blue Medicare card** to complete this section.

- Fill out this information as it appears on your Medicare card.

  OR

- Attach a copy of your Medicare card or your letter from Social Security or the Railroad Retirement Board.

Name (as it appears on your Medicare card)	
Medicare number	
Is entitled to	Effective date
HOSPITAL (Part A)	
MEDICAL (Part B)	
You must have Medicare Part A and Part B to join a Medicare Advantage plan.	

Please respond to all the questions	
1. Are you the retiree? If yes, retirement date (month/day/year) _____ If no, name of retiree _____	☐ **Yes** ☐ **No**
2. Are you covering a spouse or dependent under this employer or union plan? If yes, name of spouse _____ Name(s) of dependent(s) _____	☐ **Yes** ☐ **No**
3. Do you work? **Does your spouse work?**	☐ **Yes** ☐ **No** ☐ **Yes** ☐ **No**
4. Some individuals may have other drug coverage, including other private insurance, Worker's Compensation, VA benefits or State pharmaceutical assistance programs. **Will you have other prescription drug coverage in addition to Vermont Blue Advantage Group PPO? If "yes," please list your other coverage and your identification (ID) number(s) for this coverage.** Name of other coverage _____ ID # for coverage _____	☐ **Yes** ☐ **No**
5. Are you a resident of a long-term care facility, such as a nursing home? If yes, please provide the following information. Name of facility _____ Facility street address _____ City _____ State _____ ZIP code _____ Phone number _____	☐ **Yes** ☐ **No**

6. Name of chosen Primary Care Physician, clinic, or health center (optional)

_____

This enrollment application is part of your Vermont Blue Advantage Group PPO enrollment kit. Other important materials you should review before joining this plan are included with this form:

- A cover letter with important deadlines and information (such as the date your enrollment form is due and where to send it)
- A Benefits-at-a-Glance booklet
- A Centers for Medicare & Medicaid Services Stars Ratings flyer (measures how well Medicare Advantage plans perform in several areas)

Please contact Vermont Blue Advantage PPO Customer Service at **1-800-572-0280** (TTY users call 711) if you need information in an accessible format or language other than what is listed below. Customer Service hours are Monday through Friday, 8 a.m. to 8 p.m. Eastern time, with weekend hours October 1 to March 31. You can also visit **www.VermontBlueAdvantage.com**.

Select one if you want us to send you information in a language other than English. (optional)

☐ Spanish ☐ Other _____

Select one if you want us to send you information in an accessible format. (optional)

☐ Large print ☐ Audio CD ☐ Data CD

The fields in this section are optional

Answering these questions is your choice. You can't be denied coverage because you don't fill them out.

Are you Hispanic, Latino/a, or Spanish origin? Select all that apply.

- ☐ No, Not of Hispanic, Latino/a, or Spanish origin
- ☐ Yes, Mexican, Mexican American, Chicano/a
- ☐ Yes, Puerto Rican
- ☐ Yes, Cuban
- ☐ Yes, another Hispanic, Latino/a, or Spanish origin
- ☐ **I choose not to answer**

What is your race? Select all that apply.

- ☐ American Indian or Alaska Native

Asian

- ☐ Asian Indian
- ☐ Chinese
- ☐ Filipino
- ☐ Japanese
- ☐ Korean
- ☐ Vietnamese
- ☐ Other Asian

- ☐ Black or African American

Native Hawaiian and Pacific Islander

- ☐ Guamanian or Chamorro
- ☐ Native Hawaiian
- ☐ Samoan
- ☐ Other Pacific Islander

- ☐ White
- ☐ **I choose not to answer**

Please read and sign below

By completing this enrollment application, I agree to the following:

Vermont Blue Advantage Group PPO is a Medicare Advantage plan and has a contract with the Federal government. I will need to keep my Medicare Parts A and B. I can only be in one Medicare Advantage plan at a time and I understand that my enrollment in this plan will automatically end my enrollment in another Medicare health plan. It is my responsibility to inform the plan of any prescription drug coverage that I have or may get in the future.

Enrollment in this plan is generally for the entire year. Once I enroll, I may leave this plan or make changes only at certain times of the year if an enrollment period is available (Example: Annual Enrollment Period from October 15 - December 7), or under certain special circumstances. As a Medicare Advantage PPO member, I understand that Vermont Blue Advantage Group PPO works differently than a Medicare supplemental plan. Vermont Blue Advantage Group PPO pays instead of Medicare, and I will be responsible for the amounts that Vermont Blue Advantage Group PPO does not cover, such as copayments or coinsurances. Original Medicare will not pay for my health care while I am enrolled in Vermont Blue Advantage Group PPO.

Before seeing a provider, I should verify that the provider will accept Medicare. I understand that if my provider does not accept Medicare, I will need to find another provider who will, or my out-of-pocket costs may be greater. Out-of-network/non-contracted providers are under no obligation to treat Vermont Blue Advantage Group PPO members, except in emergency situations. For a decision about whether we will cover an out-of-network service, we encourage you or your provider to ask us for a pre-service organization determination before you receive the service. Please call our customer service number or see your *Evidence of Coverage* for more information, including the cost-sharing that applies to out-of-network services.

Vermont Blue Advantage Group PPO serves a specific service area. If I move out of the area that Vermont Blue Advantage Group PPO serves, I need to notify the plan so I can disenroll and find a new plan in my new area. Once I am a member of Vermont Blue Advantage Group PPO, I have the right to appeal plan decisions about payment or services if I disagree. I will read the *Evidence of Coverag*e document from Vermont Blue Advantage Group PPO when I receive it to know which rules I must follow in order to receive coverage with this Medicare Advantage plan. I understand that people with Medicare aren't usually covered under Medicare while out of the country except for limited coverage near the U.S. border.

I understand that beginning on the date Vermont Blue Advantage Group PPO coverage begins, I must get all of my health care from Vermont Blue Advantage Group PPO, except for emergency or urgently needed services or out-of-area dialysis services. Services authorized by Vermont Blue Advantage Group PPO and other services contained in my Vermont Blue Advantage Group PPO *Evidence of Coverage* document (also known as a member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR VERMONT BLUR ADVANTAGE GROUP PPO WILL PAY FOR THE SERVICES.**

I understand that if I am receiving assistance from a sales agent, broker, or other individual employed by or contracted with Vermont Blue Advantage Group PPO, he/she may be paid based on my enrollment in Vermont Blue Advantage Group PPO.

Counseling services may be available in my state to provide advice concerning Medicare supplement insurance or other Medicare Advantage or Prescription Drug plan options, medical assistance through the State Medicaid Program and the Medicare Savings Program. (Continued on page 5)

Please read and sign below (Continued)

Release of Information: By joining this Medicare health plan, I acknowledge that the Vermont Blue Advantage Group PPO will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that Vermont Blue Advantage Group PPO will release my information, including my prescription drug event data, to Medicare, who may release it for research and other purposes that follow all applicable federal statutes and regulations. The information on this enrollment form is correct to the best of my knowledge. I understand that if I intentionally provide false information on this form, I will be disenrolled from the plan.

I understand that my signature (or the signature of the person authorized to act on my behalf under the laws of the state where I live) on this application means that I have read and understand the contents of this application. If signed by an authorized individual (as described above), this signature certifies that: 1) this person is authorized under state law to complete this enrollment and 2) documentation of this authority is available upon request by Vermont Blue Advantage Group PPO or by Medicare.

Please sign below. By signing below, you have read the above information and you acknowledge you received a cover letter with this form as well as a Benefits-at-a-Glance booklet and Stars Rating flyer.	
Signature	Today's date

If you are the authorized representative, you must sign above and provide the following information.

Name		
Address		
City	State	ZIP code

Phone number	Relationship to enrollee

Complete this section if you're an individual (i.e., agent, broker, SHIP counselor, family member, or other third party) helping an enrollee fill out this form.

Name: _____

Relationship to enrollee: _____

Signature: _____

National Producer Number (Agents/Brokers only): _____

Please send your completed enrollment application to:

University of Vermont
Human Resources – Waterman 228
85 South Prospect Street
Burlington, VT 05405

Or email to: **hrinfo@uvm.edu**

PRIVACY ACT STATEMENT
The Centers for Medicare & Medicaid Services (CMS) collects information from Medicare plans to track beneficiary enrollment in Medicare Advantage (MA) or Prescription Drug Plans (PDP), improve care, and for the payment of Medicare benefits. Sections 1851 and 1860D-1 of the Social Security Act and 42 CFR §§ 422.50, 422.60, 423.30 and 423.32 authorize the collection of this information. CMS may use, disclose and exchange enrollment data from Medicare beneficiaries as specified in the System of Records Notice (SORN) "Medicare Advantage Prescription Drug (MARx)", System No. 09-70-0588. Your response to this form is voluntary. However, failure to respond may affect enrollment in the plan.