

Coverage Begins on the 31st day after the date of hire. If this form is submitted between the 31st and 60th day after date of hire, coverage is effective on the date this form is received by the Benefits Division.

❖ **RETIREE INFORMATION**

Name: _____ Employee ID: _____
 Date of Birth: _____ SSN: _____
 Home Phone: _____ Work Phone: _____

Return all completed forms to:
 STATE OF VERMONT
 Retirement Division
 109 State Street
 Montpelier, VT 05620-1701

❖ **ACTION REQUEST**

Annual Open Enrollment Remove/Add Dependent Cancel Coverage

If Add/Remove, please give reason and effective date (i.e. Birth, Death, Marriage, Divorce and Date)

❖ **STATUS**

Single Married* Domestic Partner Widowed Divorced Dissolution Domestic Partnership or Civil Union
 If status has changed, please provide date of event _____
 * Married same-sex individuals need to complete and submit a Qualified Dependent Declaration with this application

❖ **BENEFITS**

#1. CHOOSE MEDICAL PLAN

#2. CHOOSE COVERAGE TYPE

I select the MEDICAL coverage to the RIGHT (Complete 1 & 2 plus the Dependent section below)

SelectCare POS
 TotalChoice
 HealthGuard PPO

Retiree Only
 Two Person
 Family Plan
 (Retiree + 2 or more)

Either myself, my spouse, or (one of) my dependents is eligible for Medicare Part A and/or Part B.

PLEASE PROVIDE ALL REQUESTED INFORMATION BELOW AND SIGN THE NEXT PAGE

❖ **YOU & DEPENDENTS**

RELATIONSHIP CODES: Spouse = SP; Child = CH; Domestic or Civil Union Partner = NQP

Fill in your own information on the first line. Your dependents include your spouse, civil union partner, qualified domestic partner, unmarried children under age 19 (or to age 23, if full-time students), including children of your civil union or qualified domestic partner. If you choose the SelectCare POS Plan, please indicate a Provider ID number and whether each dependent is a patient of this physician. Provider ID numbers can be found on the medical carrier's website.

	Coverage Election		Person Has Other Insurance
	Medical	Medicare-eligible	
Retiree Coverage	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
SelectCare Provider ID: _____		Existing Patient? <input type="checkbox"/> Y <input type="checkbox"/> N	

	Coverage Election		Person Has Other Insurance	Enrolled as a Full-time Student
	Medical	Dental		
Name: _____	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
Relationship: _____		Date of Birth: _____	<input type="checkbox"/> Male <input type="checkbox"/> Female	SSN: _____
SelectCare Provider ID: _____		Existing Patient? <input type="checkbox"/> Y <input type="checkbox"/> N		

	Coverage Election		Person Has Other	Enrolled as a
	Medical	Dental	Insurance	Full-time Student
Name: _____	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
Relationship: _____	Date of Birth: _____		<input type="checkbox"/> Male <input type="checkbox"/> Female	SSN: _____
SelectCare Provider ID: _____	Existing Patient? <input type="checkbox"/> Y <input type="checkbox"/> N			

	Coverage Election		Person Has Other	Enrolled as a
	Medical	Dental	Insurance	Full-time Student
Name: _____	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
Relationship: _____	Date of Birth: _____		<input type="checkbox"/> Male <input type="checkbox"/> Female	SSN: _____
SelectCare Provider ID: _____	Existing Patient? <input type="checkbox"/> Y <input type="checkbox"/> N			

	Coverage Election		Person Has Other	Enrolled as a
	Medical	Dental	Insurance	Full-time Student
Name: _____	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
Relationship: _____	Date of Birth: _____		<input type="checkbox"/> Male <input type="checkbox"/> Female	SSN: _____
SelectCare Provider ID: _____	Existing Patient? <input type="checkbox"/> Y <input type="checkbox"/> N			

	Coverage Election		Person Has Other	Enrolled as a
	Medical	Dental	Insurance	Full-time Student
Name: _____	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
Relationship: _____	Date of Birth: _____		<input type="checkbox"/> Male <input type="checkbox"/> Female	SSN: _____
SelectCare Provider ID: _____	Existing Patient? <input type="checkbox"/> Y <input type="checkbox"/> N			

	Coverage Election		Person Has Other	Enrolled as a
	Medical	Dental	Insurance	Full-time Student
Name: _____	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
Relationship: _____	Date of Birth: _____		<input type="checkbox"/> Male <input type="checkbox"/> Female	SSN: _____
SelectCare Provider ID: _____	Existing Patient? <input type="checkbox"/> Y <input type="checkbox"/> N			

USE SECOND FORM FOR MORE THAN 5 DEPENDENTS

I hereby request the above action and authorize the Department of Human Resources to withhold from my wages appropriate deduction(s), if any, toward the cost of coverage. I understand that any medical information that is pertinent and necessary for the payment of claims for me or my eligible dependents can be used in accordance with the privacy rules established by the Health Insurance Portability and Accountability Act. I certify that the above information is complete and correct and that all claims submitted will only be for eligible plan members.

EMPLOYEE SIGNATURE: _____ DATE: _____

FOR BENEFITS OFFICE ONLY

Hire Date: _____ Coverage Term Date: _____ Coverage Term Date: _____
 Network: _____ Branch: _____ Effective Pay Date: _____