

Catamount Health Application and Change Form

Section 1: Subscriber Coverage Information

NAME:			SOCIAL SECURITY NO.:	DATE OF BIRTH:
Last Name	M.I.	First Name	E-MAIL ADDRESS:	
PHYSICAL ADDRESS (REQUIRED):			HOME PHONE NO.:	RESIDENTIAL STATUS:
City	State	ZIP Code		<input type="checkbox"/> Vermont Resident <input type="checkbox"/> US Citizen or Resident Alien Status
MAILING ADDRESS:			MARITAL STATUS:	GENDER:
City	State	ZIP Code	<input type="checkbox"/> Married/Party to a Civil Union <input type="checkbox"/> Single <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	<input type="checkbox"/> Male <input type="checkbox"/> Female

Are you applying for coverage or informing us of a change?

New application

Change

IF CHANGE, PLEASE CHECK REASON FOR CHANGE BELOW:

- Cancellation
 Birth
 Marriage/Civil Union
 Adoption (legal documentation required)
 Divorce (divorce decree required if proving coverage for children)

EFFECTIVE DATE OF CHANGE:

Section 2: Family Members You Want Covered by this Plan

LIST ALL ELIGIBLE DEPENDENTS (attach a separate sheet if necessary)	STEP-CHILD	GENDER	DATE OF BIRTH		RESIDE WITH SUBSCRIBER	FULL-TIME STUDENT AGE 19-25 (BCBSVT only)*	INCAPACITATED (If Yes, Certificate Required)
			DOB	SOCIAL SECURITY NO.			
Spouse/Party to a Civil Union	(✓)	<input type="checkbox"/> Male <input type="checkbox"/> Female	DOB	SSN	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Dependent		<input type="checkbox"/> Male <input type="checkbox"/> Female	DOB	SSN	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Dependent		<input type="checkbox"/> Male <input type="checkbox"/> Female	DOB	SSN	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Dependent		<input type="checkbox"/> Male <input type="checkbox"/> Female	DOB	SSN	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Dependent		<input type="checkbox"/> Male <input type="checkbox"/> Female	DOB	SSN	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

Dependent full-time students: For full-time students age 19 or older but under age 25, complete the following*:

I certify that the dependents listed below are full-time unmarried students earning at least 12 credit hours a semester. Recertification is required annually. (* MVP requires all individuals 19 and over to have independent memberships.)

STUDENT'S NAME	SCHOOL AND CITY WHERE LOCATED	BEGINNING DATE	ANTICIPATED GRADUATION DATE

* MVP requires all individuals 19 and over to have independent memberships.

Section 3: Eligibility for Catamount Health

1) a. Within the past 12 months, have you had health insurance or employer-sponsored coverage that covered both physician and hospital services?

Yes No Effective dates (if applicable): From ____ / ____ / ____ To ____ / ____ / ____

b. If yes, was it lost due to any of the following reasons:

- | | |
|--|---|
| <input type="checkbox"/> Loss of employment | <input type="checkbox"/> No longer receiving COBRA, VIPER, or other state continuation coverage |
| <input type="checkbox"/> Death of principal policyholder | <input type="checkbox"/> College or university-sponsored health insurance became unavailable |
| <input type="checkbox"/> Divorce or dissolution of a civil union | <input type="checkbox"/> No longer qualifying as a dependent under a parent's or caretaker's plan |
| <input type="checkbox"/> No longer qualifying for VHAP/Medicaid/Dr. Dynasaur | <input type="checkbox"/> Reduction in hours and no longer qualify for employer's insurance |

c. Have you been enrolled in a non-group health plan (a plan not sponsored by an employer or association) with a deductible of \$7,500 per individual or \$15,000 per family for more than six months?

Yes No Effective dates (if applicable): From ____ / ____ / ____ To ____ / ____ / ____

Name of insurance company _____

d. Have you lost health insurance due to domestic violence or abuse? Yes No (If you checked yes, we will send you additional documentation that you need to complete.)

Important Note: If you had a gap in health coverage, there may be a waiting period for coverage for some pre-existing medical conditions. These waiting periods may be waived if a chronic care program is available and you participate in the program. Also, waiting periods may be shortened or eliminated if you have prior or existing health coverage. Please attach proof of your prior or current coverage to this application. [We will accept a certificate of creditable coverage from your previous health plan, or if a certificate is not available, please submit other proof of coverage such as explanations of benefits (EOBs) or other correspondence from the plan indicating coverage, pay stubs showing a payroll deduction for health coverage, a health plan identification card or other evidence that you had health coverage.] If you have any questions about waiting periods or creditable coverage, please contact BCBSVT or MVP at the numbers below.

2) Do you or any member of your household qualify for Medicare, Medicaid, the Vermont Health Access Plan (VHAP) or Dr. Dynasaur now? Yes No

3) Is there a group insurance plan offered at your place of employment?

Yes No

Employer: _____

If yes, state why you are not covered.

4) Is there a group insurance plan offered at your spouse's/party to a civil union's place of employment? Yes No

Employer: _____

If yes, state why you are not covered.

Section 4: Help With Paying for Catamount Health

If your income is less than the amount on this chart for your household size, you and your family might be eligible for help paying your Catamount Health premium. **This is called premium assistance.** To find out if you are eligible for premium assistance, please call Health Access Member Services for Green Mountain Care at **1 (800) 250-8427**, TDD: 1 (888) 834-7898, or go to www.GreenMountainCare.org.

If you think you may be eligible for premium assistance, STOP. Complete the Health Care Program application at www.greenmountaincare.org/application_forms.html. If you have more members than shown in your household, call Health Access Member Services for Green Mountain Care at **1 (800) 250-8427**, or TDD: 1 (888) 834-7898.

If you do not qualify for premium assistance, please enclose payment for your first month of coverage with this application and complete the section below.

NUMBER IN HOUSEHOLD	MONTHLY INCOME	YEARLY INCOME
1	Up to \$2,900	Up to \$35,000
2	Up to \$3,900	Up to \$46,300
3	Up to \$4,800	Up to \$57,600
4	Up to \$5,700	Up to \$68,900
5	Up to \$6,700	Up to \$80,100

Section 5: Plan Choice and Signature

Please choose one of the carriers below. Then mail this application with payment to the carrier of your choice.

Your application is not complete until BCBSVT or MVP receives your first month's payment. You may also call your carrier to verify coverage and start date.

I am choosing: **Blue Cross Blue Shield of Vermont**
Individual Products/Catamount
P.O. Box 186
Montpelier, VT 05601-0186
(888) 445-5805
TDD: (800) 535-2227
www.bcbsvt.com/catamount

Payment enclosed

I am choosing: **MVP Health Insurance Company**
EAS-Catamount
P.O. Box 2207
Schenectady, New York 12301-2207
(888) 687-6277
TDD: (800) 421-1220
www.mvppermont.com

Payment enclosed

I certify that the statements on this application and all information furnished by me are true and complete to the best of my knowledge. I authorize any health care provider to disclose to the insurer, 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 the insurer. I also certify that the purchase of this individual policy was not initiated, and is not sponsored or subsidized, by my employer or any affiliate or agent of my employer.

Subscriber's Signature: _____

Date: ____ / ____ / ____