

All information must be provided.
Please print in Ink or Type



www.GreenMountainCare.org

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:	EFFECTIVE DATE OF CHANGE:
<input type="checkbox"/> Cancellation <input type="checkbox"/> Birth <input type="checkbox"/> Marriage/Civil Union <input type="checkbox"/> Adoption (legal documentation required) <input type="checkbox"/> Divorce (divorce decree required if providing coverage for children)	

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:

- Loss of employment
- No longer receiving COBRA, VIPER, or other state continuation coverage
- Death of principal policyholder
- College or university-sponsored health insurance became unavailable
- Divorce or dissolution of a civil union
- No longer receiving coverage as a dependent under a parent's or caretaker's plan
- No longer qualifying for VHAP/Medicaid/Dr. Dynasaur
- 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 \$10,000 per individual or \$20,000 per family for more than six months?

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

Name of Insurance Company _____

d. Have you been formally declared uninsured by an authorized state-agency? Yes No (If yes, please enclose a copy of the letter)

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 questions about waiting periods or creditable coverage, please contact 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

I have received a letter with a premium assistance code and have enclosed a copy with this application. If yes, skip to Section 5: Plan Choice and Signature.

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 for your Catamount Health premium. This is called 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** to verify whether or not you are eligible for premium assistance.

If you have more than the above in your household call Health Access Member Services for Green Mountain Care at 1(800)250-8427 TDD: 1(888)834-7898.

NUMBER IN HOUSEHOLD	MONTHLY INCOME	YEARLY INCOME
1	Up to \$2,800	Up to \$33,800
2	Up to \$3,700	Up to \$44,600
3	Up to \$4,600	Up to \$55,400
4	Up to \$5,500	Up to \$66,200
5	Up to \$6,400	Up to \$77,000

I do NOT qualify for premium assistance and have enclosed payment for my first month of coverage with this application.

(Please include a copy of your denial letter if you have applied for assistance and been denied.)

Section 5: Plan Choice and Signature

If you were granted premium assistance, please include your premium assistance approval letter. If you have not been granted premium assistance, include your first month's payment and your denial letter if you have one. Your application is not complete until MVP receives the premium assistance approval letter or your first month's payment. You may also call your carrier to verify coverage.

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

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: ____ / ____ / ____