VERMONT HEALTH CONNECT

Form No. 205CRF
Last revised 1/2016

For Office Use Only:
☐ Contact ID ☐ SR# : _____

Change Report Form

Name: _____ SSN (last 4 digits): XXX-XX- __ __ __ __ Date of birth: _____

Address: _____

Phone: _____ ☐ Home ☐ Cell ☐ Work E-mail: _____

Please provide your contact information above. If you answer "YES" to any of the questions below, we may need to contact you to verify your information. The more details you can provide in your answers, the quicker we can update your information.

1. Has there been a change in tax filing status for any household members?

☐ **NO** – Go to the next question. ☐ **YES** – Provide the information requested below:

Name of person	Type of tax filing change (for example: filing jointly, claiming a new tax dependent, etc.)

2. Has there been a change of income or change of job for any household member?

☐ **NO** – Go to the next question. ☐ **YES** – Provide the information requested below:

Name of person	Income amount	Date of change	Company/employer	Estimated yearly income to be filed on your tax return
	$ ☐ weekly ☐ monthly ☐ biweekly ☐ yearly			$
	$ ☐ weekly ☐ monthly ☐ biweekly ☐ yearly			$

3. Did any household member lose or gain access to health insurance, including health insurance through a job or Medicare?

☐ **NO** – Go to the next question. ☐ **YES** – Provide the information requested below:

Name of person	Access to health insurance change	Date of change

4. Has the immigration status changed for anyone receiving coverage through Vermont Health Connect?

☐ **NO** – Go to the next question. ☐ **YES** – Provide the information requested below:

Name of person	Immigration status change*	Date of change	Document type	Document expiration date

5. Has there been any other change in your household such as address, email, telephone number, number of household members, incarceration, or any other changes?

☐ **NO** – Go to the next question. ☐ **YES** – Provide the information requested below:

Name of person	Explain change	Date of change

6. Does any household member want to terminate coverage through Vermont Health Connect for the upcoming year?

☐ **NO** ☐ **YES** – Provide the name(s): _____

NEXT STEPS

Sign this form below, and send it to the address provided at the bottom. When we receive your signed Change Report Form, we will update your case with the new information you have provided. **We may have to contact you to review the information, so please make sure you have entered your phone number and e-mail address correctly on the front page of this form.** Once we update your case with the new information, we will send you a notice to let you know if your eligibility for healthcare benefits has changed.

Depending on the change that you reported, you may be able to select a different health plan if you want to. If you are eligible to change your plan, you will have 60 days from the day the change occurred to do so. This is called a special enrollment period. You can find out more information about special enrollment periods here: http://info.healthconnect.vermont.gov/QualifyingEvents

CONTINUE TO REPORT CHANGES

If you are enrolled in **Medicaid/Dr. Dynasaur**, you must report changes in your household within **10 days**. If you are enrolled in a **Qualified Health Plan and receive premium assistance**, you must report any changes within **30 days**.

We need the information asked for here to decide if you qualify for Medicaid/Dr. Dynasaur or tax credits and cost-sharing reductions that help you pay for health coverage. We will check your answers using information we get from electronic data sources, including federal tax returns. If the information does not match, we may ask you to send us proof.

Changes can be reported by completing this form, calling the Customer Support Center at **1-855-899-9600**, or by visiting the website to fill out and submit a Change Report Form electronically at https://apps.health.vermont.gov/VHCForm/ChangeReport

SIGN THIS FORM

It is important that you sign, date, and return this form to the address below.

Signature: _____ **Date:** _____

MAIL THIS FORM

Send your form to the address below. If you have questions or need help, call the toll free number below, Monday – Friday 8am to 8pm or Saturday 8am to 1pm.