

Membership Renewal Application

Mail this application to:

Vermont Department of Health, PO Box 70 Drawer 38 (YF), Burlington, VT 05402-0070

Fax this application to:

802-657-4208

For Deaf and hard of hearing individuals, please use Vermont Relay Service 711 and give our number: 1-800-508-2222.

If you have questions or need interpretation services, call 1-800-508-2222.

Si vous avez des questions ou besoin de services d'interprétation, composez le 1-800-508-2222.

Ukoliko imate dodatnih pitanja ili Vam je potreban prevodilac, javite se na 1-800-508-2222.

Si usted tiene preguntas o necesita servicios de interpretación, llame al 1-800-508-2222.

Haddii aad su'aalo qabto ama aad u baahan tahay adeeg tarjumaan, wac lambarka hoos ku qoran 1-800-508-2222.

Kama una maswali au unahitaji huduma za tafsiri, piga 1-800-508-2222.

စကားပြန် ဝန်ဆောင်မှုလုပ်ငန်းကိုအလိုရှိပါက 1-800-508-2222 သို့ ဖုန်းဆက်ခေါ်ပါ။

यदि तपाईंलाई दोभाषे सेवाको जरुरत परेमा, 1-800-508-2222 मा कल गर्नुहो

Section 1: About You

Name:

Date of birth (mm/dd/yyyy):

Pronouns: she/her he/him they/them other (please specify):

Street address (required): I do not currently have a permanent address

City/Town:

State:

Zip Code:

Mailing address (if different than above):

City/Town:

State:

Zip Code:

E-mail address:

Best phone number to reach you at:

Home

Work

Cell

(____) _____ - _____

Is it ok to leave a message?

Yes

No

Do you identify as an LGBTQ+ person?

Yes No Prefer not to answer

Do you have a physical, mental, learning, or emotional health condition or disability?

Yes No
 Prefer not to answer

The You First program asks for personal information about race, ethnicity, education, gender identity, sexuality, disability, and language to ensure we are reaching all program-eligible Vermonters. Your answers are very helpful to our team in our work to reduce preventable differences in health outcomes, but you can choose the 'prefer not to answer' response option.

Section 2: Income

Total household income before taxes: \$ _____

each year each month each week every other week

Total number of people who live on this income: _____

(Include yourself, spouse/partner, children, or others that live on this income)

Section 3: Health Insurance

Do you have health insurance?

- No, I do NOT have health insurance right now.
- Yes, I have health insurance.

If you have insurance, please tell us about your insurance below. Most of the information is on your insurance card.

Name of insurance company:

Coverage start date:

Policy holder's name

Policy or ID number:

Group or account number: