

Please Read the Instructions Before Filling Out This Form.



Please **TYPE OR PRINT CLEARLY** using blue or black ink to avoid coverage delay or type in information

MASSACHUSETTS

Enrollment and Change Form

| 1. To Be Filled Out by Your Employer | | | | | | |
|--|--|---|---|---|---|--|
| Company Name | | Current Medical Group #: | | Medical Group #, Transferring To: | | |
| Current BCBS ID #, If any | Requested Effective Date MM DD YYYY | Date of Hire MM DD YYYY | | Current Dental Group #: | Dental Group #, Transferring To | |
| Type of Transaction <input type="checkbox"/> ADD <input type="checkbox"/> CANCEL <input type="checkbox"/> CHANGE Three digit termination code <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> TRANSFER | | Remarks: (i.e., qualifying event for a new add, change to family or other instruction) <input type="checkbox"/> Open Enrollment <input type="checkbox"/> Change to Family <input type="checkbox"/> Loss of Coverage (HIPAA Continuation of Coverage Letter required) <input type="checkbox"/> New Hire <input type="checkbox"/> Add Spouse <input type="checkbox"/> Other: _____ <input type="checkbox"/> COBRA <input type="checkbox"/> Add Dependent | | | | |
| 2. Yourself (Member 1) | | | | | | |
| What products? <input type="checkbox"/> Access Blue <input type="checkbox"/> Blue Medicare Rx (Part D) <input type="checkbox"/> HMO Blue New England <input type="checkbox"/> Network Blue <input type="checkbox"/> Blue Choice <input type="checkbox"/> Dental Blue <input type="checkbox"/> Managed Blue for Seniors <input type="checkbox"/> PPO <input type="checkbox"/> Blue Choice New England <input type="checkbox"/> HMO Blue <input type="checkbox"/> Medex (Group) <input type="checkbox"/> Saver Blue | Membership Type (Medical) <input type="checkbox"/> 2 person <input type="checkbox"/> Family | | Membership Type (Dental) <input type="checkbox"/> Individual <input type="checkbox"/> Family | | | |
| Your First Name | M.I. | Last Name | | Sex | Date of Birth | |
| Street Address/ P.O. Box # | Apt. # | City/ Town | | State | Zip Code | |
| Phone () | | | | | | |
| Social Security # (REQUIRED) ¹ | | Other Insurance? ² Y <input type="checkbox"/> / N <input type="checkbox"/> | Other Insurance Company Name | | Member Identification Number | |
| PCP ID # (see instructions) | | Name of PCP | | | City / State | |
| Are you covered by Medicare? ² Y <input type="checkbox"/> / N <input type="checkbox"/> | | Part A Effective Date MM DD YYYY | Part B Effective Date MM DD YYYY | Part D Effective Date MM DD YYYY | Medicare # | <input type="checkbox"/> 65+ <input type="checkbox"/> Disabled <input type="checkbox"/> ESRD If Retired, Date |
| 3. Member 2 Please Check One: <input type="checkbox"/> Spouse <input type="checkbox"/> Divorced Spouse (court ordered) | | | | Plan Type: <input type="checkbox"/> Medical <input type="checkbox"/> Dental | | |
| First Name | M.I. | Last Name | | Sex | Date of Birth | |
| Social Security # (REQUIRED) ¹ | | Phone () | Other Insurance? ¹ Y <input type="checkbox"/> / N <input type="checkbox"/> | Other Insurance Company Name | | Member Identification Number |
| PCP ID # (see instructions) | | Name of PCP | | | City / State | |
| Are you covered by Medicare? ² Y <input type="checkbox"/> / N <input type="checkbox"/> | | Part A Effective Date MM DD YYYY | Part B Effective Date MM DD YYYY | Part D Effective Date MM DD YYYY | Medicare # | <input type="checkbox"/> 65+ <input type="checkbox"/> Disabled <input type="checkbox"/> ESRD If Retired, Date |
| Actively Working? Y <input type="checkbox"/> / N <input type="checkbox"/> | | | | | | |
| 4. Your Eligible Dependents (Member 3, 4, and 5) | | | | | | |
| Dependent's First Name 3.) | | M.I. | Last Name | | Sex | Date of Birth |
| Social Security # (REQUIRED) ¹ | | PCP ID # (see instructions) | | Name of PCP | | |
| Is this your current PCP? Y <input type="checkbox"/> / N <input type="checkbox"/> | | Disabled and aged 26 or older <input type="checkbox"/> | | | Plan Type: <input type="checkbox"/> Medical <input type="checkbox"/> Dental | |
| Dependent's First Name 4.) | | M.I. | Last Name | | Sex | Date of Birth |
| Social Security # (REQUIRED) ¹ | | PCP ID # (see instructions) | | Name of PCP | | |
| Is this your current PCP? Y <input type="checkbox"/> / N <input type="checkbox"/> | | Disabled and aged 26 or older <input type="checkbox"/> | | | Plan Type: <input type="checkbox"/> Medical <input type="checkbox"/> Dental | |
| Dependent's First Name 5.) | | M.I. | Last Name | | Sex | Date of Birth |
| Social Security # (REQUIRED) ¹ | | PCP ID # (see instructions) | | Name of PCP | | |
| Is this your current PCP? Y <input type="checkbox"/> / N <input type="checkbox"/> | | Disabled and aged 26 or older <input type="checkbox"/> | | | Plan Type: <input type="checkbox"/> Medical <input type="checkbox"/> Dental | |
| Please check if you are using separate forms for additional dependent children <input type="checkbox"/> | | | | Total # of dependents: _____ | | |
| 5. Personal Savings Account | | | | | | |
| <input type="checkbox"/> HSA: Health Savings Account | | Start Date | End Date | FSA Goal Amount (Please see instructions for limits.): \$ | | |
| <input type="checkbox"/> FSA: Health Flexible Spending Account | | Start Date | End Date | Health: \$ | | |
| <input type="checkbox"/> FSA: Dependent Care Reimbursement Account | | Start Date | End Date | Dependent Care: \$ | | |
| 6. Signature (Employer & Employee) | | | | | | |
| The information here is complete and true. I understand that Blue Cross and Blue Shield will rely on this information to enroll me and my dependents or to make changes to my membership. I understand that I should read the subscriber certificate or benefit booklet provided by my employer to understand my benefits and any restrictions that apply to my health care plan. I understand that Blue Cross and Blue Shield may obtain personal and medical information about me to carry out its business, and that it may use and disclose that information in accordance with law. I acknowledge that I may obtain further information about the collection, use, and disclosure of my information in "Our Commitment to Confidentiality," Blue Cross and Blue Shield's notice of privacy practices. | | | | | | |
| Employee's Signature _____ | | Date _____ | Employer's Signature _____ | | Date _____ | |

1. REQUIRED: Under the Affordable Care Act, we are required to collect the Social Security number for you and any dependent enrolling in your plan.

Blue Cross Blue Shield of Massachusetts is an Independent Licensee of the Blue Cross and Blue Shield Association.