MASSACHUSETTS

Blue20/20

# Application / Change Form

☐ **New Enrollee**
(Please complete A, C, D, and E)

☐ **Change Request**
(For changes, complete Sections A, B, and all other applicable sections. Plan changes can only be made at Open Enrollment or due to a qualifying event.)

☐ **Termination Date:** _____

Please print clearly.
Please use a black or blue pen.

Blue 20/20 Group No.
MIIA Client

## A. Employee Information

| | | | |
|---|---|---|---|
| Name of Employer: | | Effective Date: | Dept./Division: |
| Social Security Number: | Date of Birth: | Sex: ☐ Male ☐ Female | |
| Last Name: | First Name: | MI: | Marital Status: ☐ Single ☐ Married |
| Mailing Address: | | City: | State: / Zip Code: |
| Date of Hire: | Home Phone Number: | Work Phone Number: | Email Address: |

## B. If Making a Change from Previous Enrollment

**Check All That Apply:**

- ☐ Name Change
- ☐ Employee SSN Correction
- ☐ Add/Remove Dependent
- ☐ Address/Telephone Number Change
- ☐ Date of Birth Correction
- ☐ Late Enrollee
- ☐ Other:

**Add Dependent(s):**

**Date of Occurrence**

- ☐ Marriage _____
- ☐ Newborn (up to age 1) _____
- ☐ Adoption _____
- ☐ Court Order _____
- ☐ Loss of Coverage _____
- ☐ Other _____

☐ **Remove Dependent(s)** _____

Date: _____

Reason:

**Reinstate Coverage:**

Date: _____

Reason:

**Terminate Coverage:**

Date: _____

Reason:

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## C. Coverage Selection

**Options Selected:** ☐ Employee ☐ Employee plus Spouse
☐ Employee plus One or More Children ☐ Family

## D. Family Information—Complete for anyone taking or dropping Blue 20/20 Coverage*

| | Name (First, MI, Last Name) | Social Security Number | Date of Birth mm/dd/yyyy | Relationship | Sex |
|---|---|---|---|---|---|
| ☐ Add / ☐ Delete | | | | | ☐ M ☐ F |
| ☐ Add / ☐ Delete | | | | | ☐ M ☐ F |
| ☐ Add / ☐ Delete | | | | | ☐ M ☐ F |
| ☐ Add / ☐ Delete | | | | | ☐ M ☐ F |
| ☐ Add / ☐ Delete | | | | | ☐ M ☐ F |
| ☐ Add / ☐ Delete | | | | | ☐ M ☐ F |
| ☐ Add / ☐ Delete | | | | | ☐ M ☐ F |

*Application does not guarantee enrollment.

Eligibility Notes:

1. Employees are eligible for coverage if they meet the definition of an eligible employee as defined by their employer and Blue Cross Blue Shield of Massachusetts.
2. Domestic Partners are eligible for coverage if they meet the definition of a Domestic Partner and if allowed by the employer.
3. Dependent Children are eligible for coverage up to age 26.

## E. Statement of Understanding

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 vision plan.

Signature of Employee _____ Date _____

## Visit us at blue2020ma.com

Blue Cross Blue Shield of Massachusetts complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex, sexual orientation or gender identity.

ATTENTION: If you don't speak English, language assistance services, free of charge, are available to you. Call Member Services at the number on your ID Card (TTY: 711).

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia con el idioma. Llame al número de Servicio al Cliente que figura en su tarjeta de identificación (TTY: 711).

ATENÇÃO: Se fala português, são-lhe disponibilizados gratuitamente serviços de assistência de idiomas. Telefone para os Serviços aos Membros, através do número no seu cartão ID (TTY: 711).