MASSACHUSETTS

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

Please Read The Instructions Before Filling Out This Form.

Please PRINT CLEARLY using blue or black ink to avoid coverage delay.

Enrollment and Change Form

Please mail to: BCBS, P.O. Box 986001, Boston, MA 02298-6001

1. To Be Filled Out by Your Employer

Company Name	Current Medical Group #	Medical Group # Transferring To

Current BCBS ID Number, if any	Requested Effective Date (MM DD YYYY)	Date of Hire (MM DD YYYY)	Current Dental Group #	Dental Group # Transferring To

Type of Transaction
- ☐ ADD
- ☐ CHANGE
- ☐ TRANSFER
- ☐ CANCEL

(If canceling, please see instructions for three digit termination code.) ☐☐☐

Remarks: (i.e., qualifying event for a new add, change to family, or further instruction)

- ☐ Open Enrollment
- ☐ New Hire
- ☐ COBRA

Change to Family
- ☐ Add Spouse
- ☐ Add Dependent

- ☐ Loss of Coverage (HIPAA Continuation of Coverage Letter Required)
- ☐ Other_____

2. Tell Us About Yourself (Member 1)

What products are you selecting?
- ☐ HMO Blue
- ☐ Network Blue
- ☐ Blue Choice
- ☐ Saver Product
- ☐ Dental Blue
- ☐ Access Blue
- ☐ PPO
- ☐ HMO Blue New England
- ☐ Blue Choice New England
- ☐ Other (Write Name of Plan)

Kind of Membership (Medical)
- ☐ Individual
- ☐ Family

Kind of Membership (Dental)
- ☐ Individual
- ☐ Family

Your First Name	M.I.	Last Name	Sex	Date of Birth (MM DD YYYY)

Street Address / P.O. Box #	Apt. #	City/Town	State	Zip Code

Social Security #	Telephone # (area code) ( )	Other Insurance? * Y / N	Other Health Insurance Company Name	City/State

PCP ID #: (see instructions)	Name of PCP	City/State	Is this your current PCP? Mark X, if yes.
			☐

Are you Covered by Medicare? * Y / N	Part A Effective Date (MM DD YYYY)	Part B Effective Date (MM DD YYYY)	Part D Effective Date (MM DD YYYY)	Medicare #: ☐ 65+ ☐ Disabled ☐ ESRD	Actively Working Y / N If Retired, Date:

3. Tell Us About (Member 2)

Please check one: ☐ Spouse ☐ Domestic Partner ☐ Divorced Spouse (court ordered)

Member 2's First Name	M.I.	Last Name	Sex	Date of Birth (MM DD YYYY)

Street Address / P.O. Box #	Apt. #	City/Town	State	Zip Code

Social Security #	Telephone # (area code) ( )	Other Insurance? * Y / N	Other Health Insurance Company Name	City/State

PCP ID #: (see instructions)	Name of PCP	City/State	Is this your current PCP? Mark X, if yes.
			☐

Is Member 2 Covered by Medicare? * Y / N	Part A Effective Date (MM DD YYYY)	Part B Effective Date (MM DD YYYY)	Part D Effective Date (MM DD YYYY)	Medicare #: ☐ 65+ ☐ Disabled ☐ ESRD	Actively Working Y / N If Retired, Date:

** If you have not indicated Yes or No regarding your Medicare or other insurance status, you may receive a follow-up questionnaire.*

4. Tell Us About Your Dependents (Members 3, 4, and 5)

Dependent's First Name	M.I.	Last Name	Sex	Full-time student? Age 19 or over Y / N
3.)				

Social Security #	Date of Birth	PCP ID Number (see instructions)	Name of PCP	Is this your current PCP? Mark X, if yes.
				☐

Dependent's First Name	M.I.	Last Name	Sex	Full-time student? Age 19 or over Y / N
4.)				

Social Security #	Date of Birth	PCP ID Number (see instructions)	Name of PCP	Is this your current PCP? Mark X, if yes.
				☐

Dependent's First Name	M.I.	Last Name	Sex	Full-time student? Age 19 or over Y / N
5.)				

Social Security #	Date of Birth	PCP ID Number (see instructions)	Name of PCP	Is this your current PCP? Mark X, if yes.
				☐

Please check if you are using separate forms for additional dependent children. ☐ Total # of Dependents:_____

5. Select Personal Savings Account (if applicable)

☐ HSA	Start Date	End Date	FSA GOAL AMOUNTS: (Please see instructions for maximum limits
☐ FSA - Health	Start Date	End Date	Health $:
☐ FSA - Dep.	Start Date	End Date	Dependent Care $:

6. Signatures (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 _____