Please Read the Instructions Before Filling Out This Form.

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

MASSACHUSETTS

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

Enrollment and Change Form.

Please mail to: P.O. Box 986001
Boston, MA 02298 or fax to **1-617-246-7531**

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
❒ 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 other 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 Blue
❒ Dental Blue
❒ Access Blue
❒ PPO
❒ HMO Blue New England
❒ Blue Choice New England
❒ Group Medex or Managed Blue for Seniors
❒ Blue Medicare Rx (Part D)

Kind of Membership (Medical)
❒ Individual
❒ Family

Kind of Membership (Dental)
❒ Individual
❒ Family

Your First Name	M.I.	Last Name	Sex	Date of Birth
Street Address / P.O. Box #:	Apt. #:	City / Town	State	Zip Code

Social Security # (REQUIRED)*:	Telephone #: (area code) ( )	Other Insurance?[1] Y ❒ / N ❒	Other 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
Street Address / P.O. Box #:	Apt. #:	City / Town	State	Zip Code

Social Security # (REQUIRED)*:	Telephone #: (area code) ( )	Other Insurance?[1] Y ❒ / N ❒	Other 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?[1] 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:

1. *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 Eligible Dependents (Member 3, 4, and 5)

Dependent's First Name 3.)	M.I.	Last Name	Sex	Full-time student and aged 19 or older ❒ Disabled and aged 26 or older ❒
Social Security # (REQUIRED)*:	Date of Birth	PCP ID #: (see instructions)	Name of PCP	Is this your current PCP? Mark X, if yes. ☐
Dependent's First Name 4.)	M.I.	Last Name	Sex	Full-time student and aged 19 or older ❒ Disabled and aged 26 or older ❒
Social Security # (REQUIRED)*:	Date of Birth	PCP ID #: (see instructions)	Name of PCP	Is this your current PCP? Mark X, if yes. ☐
Dependent's First Name 5.)	M.I.	Last Name	Sex	Full-time student and aged 19 or older ❒ Disabled and aged 26 or older ❒
Social Security # (REQUIRED)*:	Date of Birth	PCP ID #: (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

	Start Date:	End Date:	
☐ HSA: Health Savings Account			FSA GOAL AMOUNTS: (Please see instructions for limits.)
☐ FSA – Health: Health Flexible Spending Account	Start Date:	End Date:	Health $:
☐ FSA – Dep.: 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 _____

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