

**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 Licensee of the Blue Cross and Blue Shield Association.



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"/> CHANGE <input type="checkbox"/> TRANSFER <input type="checkbox"/> CANCEL	(If canceling, please see instructions for three digit termination code.) <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>			Remarks: (i.e., qualifying event for a new add, change to family or other instruction)					
<input type="checkbox"/> Open Enrollment <input type="checkbox"/> New Hire <input type="checkbox"/> COBRA		Change to Family <input type="checkbox"/> Add Spouse <input type="checkbox"/> Add Dependent		<input type="checkbox"/> Loss of Coverage (HIPAA Continuation of Coverage Letter Required) <input type="checkbox"/> Other _____					

2. Tell Us About Yourself (Member 1)

What products are you selecting? <input type="checkbox"/> HMO Blue <input type="checkbox"/> Network Blue <input type="checkbox"/> Blue Choice <input type="checkbox"/> PPO	<input type="checkbox"/> Dental Blue	<input type="checkbox"/> HMO Blue New England <input type="checkbox"/> Blue Choice New England <input type="checkbox"/> Group Medex <input type="checkbox"/> Blue Medicare Rx (Part D)			Kind of Membership (Medical) <input type="checkbox"/> Individual <input type="checkbox"/> Family <input type="checkbox"/> Two-Person		Kind of Membership (Dental) <input type="checkbox"/> Individual <input type="checkbox"/> Family <input type="checkbox"/> Two-Person	
Your First Name		M.I.	Last Name			Sex	Date of Birth	
Street Address / P.O. Box #:			Apt. #:	City / Town		State	Zip Code	
Social Security #:		Telephone #: (area code) ()		Other Insurance?¹ Y <input type="checkbox"/> / N <input type="checkbox"/>	Other Insurance Company Name		City / State	
PCP ID #: (see instructions)		Name of PCP			City / State		Is this your current PCP? Mark X, if yes. <input type="checkbox"/>	
Are you covered by Medicare? 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		Actively Working? Y <input type="checkbox"/> / N <input type="checkbox"/> If Retired, Date:		

3. Tell Us About (Member 2)

Please Check One: Spouse Divorced Spouse (court ordered)

First Name		M.I.	Last Name			Sex	Date of Birth	
Street Address / P.O. Box #:			Apt. #:	City / Town		State	Zip Code	
Social Security #:		Telephone #: (area code) ()		Other Insurance?¹ Y <input type="checkbox"/> / N <input type="checkbox"/>	Other Insurance Company Name		City / State	
PCP ID #: (see instructions)		Name of PCP			City / State		Is this your current PCP? Mark X, if yes. <input type="checkbox"/>	
Is Member 2 covered by Medicare?¹ 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		Actively Working? Y <input type="checkbox"/> / N <input type="checkbox"/> 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	
Social Security #:		Date of Birth	PCP ID #: (see instructions)		Name of PCP		Is this your current PCP? Mark X, if yes. <input type="checkbox"/>
Dependent's First Name 4.)		M.I.	Last Name			Sex	
Social Security #:		Date of Birth	PCP ID #: (see instructions)		Name of PCP		Is this your current PCP? Mark X, if yes. <input type="checkbox"/>
Dependent's First Name 5.)		M.I.	Last Name			Sex	
Social Security #:		Date of Birth	PCP ID #: (see instructions)		Name of PCP		Is this your current PCP? Mark X, if yes. <input type="checkbox"/>

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

5. 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 _____