



MASSACHUSETTS

Blue^{20/20}

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: _____

Blue 20/20 Group No. _____

A. Employee Information

Name of Employer:		Effective Date:	Dept. / Division:	
Social Security Number:	Date of Birth:	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female		
Last Name:	First Name:	MI:	Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married	
Mailing Address:		City:	State:	Zip Code:
Date of Hire:	Home Phone Number:	Work Phone Number:	E-Mail Address:	

B. If Making a Change from Previous Enrollment

Check All That Apply: <input type="checkbox"/> Name Change <input type="checkbox"/> Employee SSN Correction <input type="checkbox"/> Add/Remove Dependent <input type="checkbox"/> Address/Telephone Number Change <input type="checkbox"/> Date of Birth Correction <input type="checkbox"/> Late Enrollee <input type="checkbox"/> Other: _____	Add Dependent(s): <input type="checkbox"/> Marriage _____ <input type="checkbox"/> Domestic Partner _____ <input type="checkbox"/> Newborn (up to age 1) _____ <input type="checkbox"/> Adoption _____ <input type="checkbox"/> Court Order _____ <input type="checkbox"/> Loss of Coverage _____ <input type="checkbox"/> Other _____ <input type="checkbox"/> Remove Dependent(s) _____ Reason: _____ _____ _____	Date of Occurrence _____ _____ _____ _____ _____ Date _____	Reinstate Coverage: Date: _____ Reason: _____ _____ _____ Terminate Coverage: Date: _____ Reason: _____ _____ _____
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C. Coverage Selection

Options Selected: Employee Employee plus Spouse or Domestic Partner
 Employee plus Child 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
<input type="checkbox"/> Add / <input type="checkbox"/> Delete					<input type="checkbox"/> F <input type="checkbox"/> M
<input type="checkbox"/> Add / <input type="checkbox"/> Delete					<input type="checkbox"/> F <input type="checkbox"/> M
<input type="checkbox"/> Add / <input type="checkbox"/> Delete					<input type="checkbox"/> F <input type="checkbox"/> M
<input type="checkbox"/> Add / <input type="checkbox"/> Delete					<input type="checkbox"/> F <input type="checkbox"/> M
<input type="checkbox"/> Add / <input type="checkbox"/> Delete					<input type="checkbox"/> F <input type="checkbox"/> M
<input type="checkbox"/> Add / <input type="checkbox"/> Delete					<input type="checkbox"/> F <input type="checkbox"/> M
<input type="checkbox"/> Add / <input type="checkbox"/> Delete					<input type="checkbox"/> F <input type="checkbox"/> M

* 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 www.blue2020ma.com



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