

Health and Dental



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 or type in information

Enrollment and Change Form.

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

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| 1. To Be Filled Out by Your Employer | | | | | |
| Company Name Town of Walpole | | Current Medical Group #: | | Medical Group #, Transferring To | |
| Current BCBS ID #, If any | Requested Effective Date 07 MM 01 DD 2024 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) Open Enrollment <input checked="" type="checkbox"/> Open Enrollment <input type="checkbox"/> New Hire <input type="checkbox"/> COBRA <input type="checkbox"/> 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"/> Network Blue NE \$100 Ded. <input type="checkbox"/> Network Blue NE \$500 Ded. <input type="checkbox"/> Network Blue Select \$500 Ded. | <input type="checkbox"/> Blue Care Elect Blue (PPO) <input type="checkbox"/> Dental Blue Freedom | Kind of Membership (Medical) <input type="checkbox"/> Individual <input type="checkbox"/> Family | | Kind of Membership (Dental) <input type="checkbox"/> Individual <input type="checkbox"/> 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 #: | 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: <input type="checkbox"/> Spouse <input type="checkbox"/> Domestic Partner <input type="checkbox"/> 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 #: | 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? 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: |
| <i>1. If you have not indicated Yes or No regarding your Medicare or other insurance status, you may receive a follow-up questionnaire.</i> | | | | | |
| 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 <input type="checkbox"/> Disabled and aged 26 or older <input type="checkbox"/> | |
| 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 | Full-time student and aged 19 or older <input type="checkbox"/> Disabled and aged 26 or older <input type="checkbox"/> | |
| 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 | Full-time student and aged 19 or older <input type="checkbox"/> Disabled and aged 26 or older <input type="checkbox"/> | |
| 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 <input type="checkbox"/> | | | Total # of Dependents: _____ | | |
| 5. Select Personal Savings Account | | | | | |
| <input type="checkbox"/> HSA | Start Date: | End Date: | FSA GOAL AMOUNTS: (Please see instructions for maximum limits.) | | |
| <input type="checkbox"/> FSA - Health | Start Date: | End Date: | Health \$: | | |
| <input type="checkbox"/> FSA - Dep. | 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 _____ | | |