

Please Read the Instructions Before Filling Out This Form.



Enrollment and Change Form

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

MASSACHUSETTS

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

2. Yourself (Member 1)

What products? <input type="checkbox"/> Access Blue <input type="checkbox"/> Blue Choice <input type="checkbox"/> Blue Choice New England	<input type="checkbox"/> Blue Medicare Rx (Part D) <input type="checkbox"/> Dental Blue <input type="checkbox"/> HMO Blue	<input type="checkbox"/> HMO Blue New England <input type="checkbox"/> Managed Blue for Seniors <input type="checkbox"/> Medex (Group)	<input type="checkbox"/> Network Blue <input type="checkbox"/> PPO <input type="checkbox"/> Saver Blue	Membership Type (Medical) <input type="checkbox"/> Individual <input type="checkbox"/> Family	Membership Type (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
Home Phone ()		Cell Phone ()		Email	
Social Security # (REQUIRED) ¹		Other Insurance? ² Y <input type="checkbox"/> / N <input type="checkbox"/>	Other Insurance Company Name		City / State
PCP ID # (see instructions)		Name of PCP			City / State
Are you covered by Medicare? ² 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 If Retired, Date

3. Member 2

Please Check One: Spouse Domestic Partner Divorced Spouse (court ordered) Plan Type: Medical Dental

First Name	M.I.	Last Name		Sex	Date of Birth
Social Security # (REQUIRED) ¹		Phone ()	Other Insurance? ¹ Y <input type="checkbox"/> / N <input type="checkbox"/>	Other Insurance Company Name	
PCP ID # (see instructions)		Name of PCP			City / State
Are you covered by Medicare? ² 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 If Retired, Date

4. Your Eligible Dependents (Member 3, 4, and 5)

Dependent's First Name 3.)	M.I.	Last Name		Sex	Date of Birth
Social Security # (REQUIRED) ¹		PCP ID # (see instructions)	Name of PCP		
Is this your current PCP? Y <input type="checkbox"/> / N <input type="checkbox"/>		Full-time student and aged 19 or older <input type="checkbox"/> Disabled and aged 26 or older <input type="checkbox"/>		Plan Type: <input type="checkbox"/> Medical <input type="checkbox"/> Dental	
Dependent's First Name 4.)	M.I.	Last Name		Sex	Date of Birth
Social Security # (REQUIRED) ¹		PCP ID # (see instructions)	Name of PCP		
Is this your current PCP? Y <input type="checkbox"/> / N <input type="checkbox"/>		Full-time student and aged 19 or older <input type="checkbox"/> Disabled and aged 26 or older <input type="checkbox"/>		Plan Type: <input type="checkbox"/> Medical <input type="checkbox"/> Dental	
Dependent's First Name 5.)	M.I.	Last Name		Sex	Date of Birth
Social Security # (REQUIRED) ¹		PCP ID # (see instructions)	Name of PCP		
Is this your current PCP? Y <input type="checkbox"/> / N <input type="checkbox"/>		Full-time student and aged 19 or older <input type="checkbox"/> Disabled and aged 26 or older <input type="checkbox"/>		Plan Type: <input type="checkbox"/> Medical <input type="checkbox"/> Dental	

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

5. Personal Savings Account

<input type="checkbox"/> HSA: Health Savings Account	Start Date	End Date	FSA Goal Amount (Please see instructions for limits.): \$
<input type="checkbox"/> FSA: Health Flexible Spending Account	Start Date	End Date	Health: \$
<input type="checkbox"/> FSA: 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 _____

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

2. If you have not indicated Y or N regarding your Medicare or other insurance status, you may receive a follow-up questionnaire.