COMPLETE SECTIONS 2 & 6 ONLY. RETURN TO BENEFITS@WELLESELYMA.GOV

Please Read the Instructions Before Filling Out This Form.

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

MASSACHUSETTS

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
WSHG - Town of Wellesley		**00-4035709**

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 ❒ CANCEL
❒ CHANGE Three digit termination code ☐☐☐
❒ TRANSFER

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. Yourself (Member 1)

What products? ❒ Access Blue ❒ Blue Choice ❒ Blue Choice New England ❒ Blue Medicare Rx (Part D) ❒ Dental Blue ❒ HMO Blue ☒ Managed Blue for Seniors ❒ Medex (Group) ❒ HMO Blue New England ❒ Network Blue ❒ PPO ❒ Saver Blue

Membership Type (Medical) ☒ Individual ☐ ☐ ☐

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 ❒ / N ❒	Other Insurance Company Name	City / State

PCP ID # (see instructions)	Name of PCP	City / State	Is this your current PCP? Y ❒ / N ❒

Are you covered by Medicare?[2] 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.

First Name	M.I.	Last Name	Sex	Date of Birth

Social Security # (REQUIRED)[1]	Phone ( )	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? Y ❒ / N ❒

Are you covered by Medicare?[2] 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

4.

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 ❒ / N ❒ Full-time student and aged 19 or older ❒ Disabled and aged 26 or older ❒ Plan Type: ❒ Medical ❒ 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 ❒ / N ❒ Full-time student and aged 19 or older ❒ Disabled and aged 26 or older ❒ Plan Type: ❒ Medical ❒ 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 ❒ / N ❒ Full-time student and aged 19 or older ❒ Disabled and aged 26 or older ❒ Plan Type: ❒ Medical ❒ Dental

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

5.

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6. Your Signature

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.

Your 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.