

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

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		Date of Hire		Current Dental Group #:		Dental Group #, Transferring To			
		MM	DD	YYYY	MM	DD	YYYY				
Type of Transaction			Remarks: (i.e., qualifying event for a new add, change to family or other instruction)								
<input type="checkbox"/> ADD <input type="checkbox"/> CANCEL <input type="checkbox"/> CHANGE Three digit termination code <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> TRANSFER			<input 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. Yourself (Member 1)											
What products?		<input type="checkbox"/> Access Blue		<input type="checkbox"/> Blue Medicare Rx (Part D)		<input type="checkbox"/> HMO Blue New England		<input type="checkbox"/> Network Blue		Membership Type (Medical) <input type="checkbox"/> Individual <input type="checkbox"/> 2 person <input type="checkbox"/> Family	
		<input type="checkbox"/> Blue Choice		<input type="checkbox"/> Dental Blue		<input type="checkbox"/> Managed Blue for Seniors		<input type="checkbox"/> PPO		Membership Type (Dental) <input type="checkbox"/> Individual <input type="checkbox"/> 2 person <input type="checkbox"/> Family	
		<input type="checkbox"/> Blue Choice New England		<input type="checkbox"/> HMO Blue		<input type="checkbox"/> Medex (Group)		<input type="checkbox"/> Saver Blue			
Your First Name			M.I.		Last Name			Sex		Date of Birth	
Street Address/ P.O. Box #			Apt. #		City/Town			State		Zip Code	
Phone ()											
Social Security # (REQUIRED) ¹				Other Insurance? ² Y <input type="checkbox"/> / N <input type="checkbox"/>		Other Insurance Company Name			Member Identification Number		
PCP ID # (see instructions)				Name of PCP				City / State		Is this your current PCP? Y <input type="checkbox"/> / N <input type="checkbox"/>	
Are you covered by Medicare? ² Y <input type="checkbox"/> / N <input type="checkbox"/>		Part A Effective Date		Part B Effective Date		Part D Effective Date		Medicare #		<input type="checkbox"/> 65+ <input type="checkbox"/> Disabled <input type="checkbox"/> ESRD If Retired, Date	
		MM	DD	YYYY	MM	DD	YYYY	MM	DD	YYYY	Actively Working? Y <input type="checkbox"/> / N <input type="checkbox"/>
3. Member 2 Please Check One: <input type="checkbox"/> Spouse <input type="checkbox"/> Divorced Spouse (court ordered)											
First Name			M.I.		Last Name			Sex		Date of Birth	
Social Security # (REQUIRED) ¹				Phone ()		Other Insurance? ² Y <input type="checkbox"/> / N <input type="checkbox"/>		Other Insurance Company Name			Member Identification Number
PCP ID # (see instructions)				Name of PCP				City / State		Is this your current PCP? Y <input type="checkbox"/> / N <input type="checkbox"/>	
Are you covered by Medicare? ² Y <input type="checkbox"/> / N <input type="checkbox"/>		Part A Effective Date		Part B Effective Date		Part D Effective Date		Medicare #		<input type="checkbox"/> 65+ <input type="checkbox"/> Disabled <input type="checkbox"/> ESRD If Retired, Date	
		MM	DD	YYYY	MM	DD	YYYY	MM	DD	YYYY	Actively Working? Y <input type="checkbox"/> / N <input type="checkbox"/>
4. Your Eligible Dependents (Member 3, 4, and 5)											
Dependent's First Name			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"/>		
Is this your current PCP? Y <input type="checkbox"/> / N <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			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"/>		
Is this your current PCP? Y <input type="checkbox"/> / N <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			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"/>		
Is this your current PCP? Y <input type="checkbox"/> / N <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 <input type="checkbox"/> 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.

Blue Cross Blue Shield of Massachusetts is an Independent Licensee of the Blue Cross and Blue Shield Association.