

Please Read the Instructions Before Filling Out This Form.



Please **TYPE OR PRINT CLEARLY**, using blue or black ink, to avoid coverage delay

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:			
	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"/> HMO Blue New England <input type="checkbox"/> PPO Blue Care Elect <input type="checkbox"/> HMO Select Network		Membership Type (Medical)	
				<input type="checkbox"/> Individual <input type="checkbox"/> Individual + One <input type="checkbox"/> Family	
First Name		M.I.	Last Name		Sex
Street Address/ P.O. Box #		Apt. #	City/ Town		State
Home Phone ()		Cell Phone ()		Email	
Social Security # (REQUIRED) ¹		Other Insurance? 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: Spouse Domestic Partner Divorced Spouse (court ordered) Plan Type: Medical Dental

First Name		M.I.	Last Name		Sex
Social Security # (REQUIRED) ¹		Phone ()	Other Insurance? 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
3.) 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		M.I.	Last Name		Sex
4.) 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		M.I.	Last Name		Sex
5.) 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're using separate forms for additional dependent children Total # of dependents: _____

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're required to collect the Social Security number for you and any dependent enrolling in your plan.