

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 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"/> New Hire <input type="checkbox"/> COBRA			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"/> Dental Blue <input type="checkbox"/> HMO Blue			<input type="checkbox"/> Managed Blue for Seniors <input type="checkbox"/> Medex (Group)		<input type="checkbox"/> PPO		
Membership Type (Medical) <input type="checkbox"/> 2 person <input type="checkbox"/> Family			Membership Type (Dental) <input type="checkbox"/> Individual <input type="checkbox"/> Family			Your First Name		M.I.		
Street Address/ P.O. Box #			Apt. #			City/ Town		State		
Phone ()			Sex			Date of Birth				
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 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		
								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)					Plan Type: <input type="checkbox"/> Medical <input type="checkbox"/> 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			Member Identification Number			Name of PCP			City / State	
Is this your current PCP? 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		
									<input type="checkbox"/> 65+ <input type="checkbox"/> Disabled <input type="checkbox"/> ESRD	
									If Retired, Date	
									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"/>			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"/>			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"/>			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.