

Please Read The Instructions Before Filling Out This Form.

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

MASSACHUSETTS

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

Enrollment and Change Form

Please mail to: BCBSMA, P.O. Box 986001, Boston, MA 02298 or fax 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	Date of Hire	Current Dental Group #:	Dental Group #, Transferring To
		MM DD YYYY	MM DD YYYY		
Type of Transaction	(If canceling, please see instructions for three digit termination code.)	Remarks: (i.e., qualifying event for a new add, change to family or other instruction)			
<input type="checkbox"/> ADD <input type="checkbox"/> CHANGE <input type="checkbox"/> TRANSFER <input type="checkbox"/> CANCEL	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<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. Tell Us About Yourself (Member 1)					
What Products are you selecting?	<input type="checkbox"/> HMO Blue <input type="checkbox"/> Network Blue <input type="checkbox"/> Blue Choice Saver Product	<input type="checkbox"/> Dental Blue <input type="checkbox"/> Access Blue <input type="checkbox"/> PPO	<input type="checkbox"/> HMO Blue New England <input type="checkbox"/> Blue Choice New England <input type="checkbox"/> Other (Write Name of Plan)	Kind of Membership (Medical)	Kind of Membership (Dental)
				<input type="checkbox"/> Individual <input type="checkbox"/> Family	<input type="checkbox"/> Individual <input type="checkbox"/> Family
Your First Name		M.I.	Last Name		Sex
Street Address / P.O. Box #:		Apt. #:	City / Town	State	Zip Code
Social Security #:		Telephone #: (area code)	Other Insurance? *	Other Insurance Company Name	City / State
		()	Y <input type="checkbox"/> / N <input type="checkbox"/>		
PCP ID #: (see instructions)		Name of PCP	City/State		Is this your current PCP?
					Mark X, if yes. <input type="checkbox"/>
Are you Covered by Medicare? *	Part A Effective Date	Part B Effective Date	Part D Effective Date	Medicare #:	Actively Working
Y <input type="checkbox"/> / N <input type="checkbox"/>	MM DD YYYY	MM DD YYYY	MM DD YYYY	<input type="checkbox"/> 65+ <input type="checkbox"/> Disabled <input type="checkbox"/> ESRD	Y <input type="checkbox"/> / N <input type="checkbox"/>
					If Retired, Date:
3. Tell Us About (Member 2) Please check one: <input type="checkbox"/> Spouse <input type="checkbox"/> Domestic Partner <input type="checkbox"/> Divorced Spouse (court ordered)					
Member 2's First Name		M.I.	Last Name		Sex
Street Address / P.O. Box #:		Apt. #:	City / Town	State	Zip Code
Social Security #:		Telephone #: (area code)	Other Insurance? *	Other Insurance Company Name	City / State
		()	Y <input type="checkbox"/> / N <input type="checkbox"/>		
PCP ID #: (see instructions)		Name of PCP	City/State		Is this your current PCP?
					Mark X, if yes. <input type="checkbox"/>
Is Member 2 Covered by Medicare? *	Part A Effective Date	Part B Effective Date	Part D Effective Date	Medicare #:	Actively Working
Y <input type="checkbox"/> / N <input type="checkbox"/>	MM DD YYYY	MM DD YYYY	MM DD YYYY	<input type="checkbox"/> 65+ <input type="checkbox"/> Disabled <input type="checkbox"/> ESRD	Y <input type="checkbox"/> / N <input type="checkbox"/>
					If Retired, Date:
* If you have not indicated Yes or No regarding your Medicare or other insurance status, you may receive a follow-up questionnaire.					
4. Tell Us About Your Dependents (Member 3, 4, and 5)					
Dependent's First Name 3.)		M.I.	Last Name		Sex
Social Security #:		Date of Birth	PCP ID #: (see instructions)	Name of PCP	Is this your current PCP?
					Mark X, if yes. <input type="checkbox"/>
Dependent's First Name 4.)		M.I.	Last Name		Sex
Social Security #:		Date of Birth	PCP ID #: (see instructions)	Name of PCP	Is this your current PCP?
					Mark X, if yes. <input type="checkbox"/>
Dependent's First Name 5.)		M.I.	Last Name		Sex
Social Security #:		Date of Birth	PCP ID #: (see instructions)	Name of PCP	Is this your current PCP?
					Mark X, if yes. <input type="checkbox"/>
Please check if you are using separate forms for additional dependent children. <input type="checkbox"/>					Total # of Dependents : _____
5. Select Personal Savings Account (Blue Healthcare Bank Members Only)					
<input type="checkbox"/> HSA	Start Date:	End Date:	FSA GOAL AMOUNTS: (Please see instructions for maximum limits.)		
<input type="checkbox"/> FSA – Health	Start Date:	End Date:	Health \$:		
<input type="checkbox"/> FSA – Dep.	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	