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

Boston, MA 02298 or fax 1-617-246-7531

1. To Be Filled Out by Your Employer

Company Name	CURRENT MEDICAL GROUP #:	Medical Group #, Transferring To

Current BCBSID#	EFFECTIVE DATE MM DD YYYY	DATE OF HIRE: MM DD YYYY	CURRENT DENTAL GROUP #:	DENTAL GROUP #, TRANSFERRING TO:

Type of Transaction
D ADD D CANCEL
DCHANGE Three digit
DTRANSFER termination code ☐☐☐

REMARKS: (I.E., QUALIFYING EVENT FOR A NEW add, change to family or other instruction)

D OPEN ENROLL D NEW HIRE D COBRA

CHANGE TO FAMILY D Add Spouse D Add Dependent

D LOSS OF COVERAGE (HIPPA CONTINUATION OF COVERAGE LETTER REQUIRE
D OTHER: _____

2. Yourself (Member 1)

What products? Blue Care Elect PPO | Network Blue HMO | Master Medical | MEDEX 2

Membership Type Individual FAMILY

Membership Type Individual FAMILY

YOUR FIRST Name	M.I.	Last Name	Sex	Date of Birth
Street Address/ POBOX #	Apt.#	City/ Town	State	Zip Code

Phone: ( )	Cell Phone ( )	EMAIL

Social Security# (REQUIRED)	Other Insurance? Yes / No	OTHER INSURANCE Company Name	City/State
PCP ID# (see instructions)	Name of PCP	City/State	Is this your current PCP? Yes / No

Are you covered by Medicare?[2] Yes / No	PART A EFFECTIVE DATE MM DD YYYY	PART B EFFECTIVE DATE MM DD YYYY		Medicare#	D 65+ D Disabled DESRD
				Actively Working? Yes / NO	IF RETIRED, Date

3. Member 2

Please Check One: D Spouse D Domestic Partner D Divorced Spouse (court ordered)

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

Social Security# (REQUIRED)	Phone ( )	OTHER INSURANCE Yes / No	OTHER INSURANCE Company Name	City/State
PCP ID# (see instructions)	Name of PCP	City/State		Is this your current PCP? YD / ND

Are you covered by Medicare?[2] Yes / NO	PART A EFFECTIVE DATE MM DD YYYY	PART B EFFECTIVE DATE MM DD YYYY		Medicare#	D 65+ D Disabled D ESRD
				Actively Working? Yes/No	IF RETIRED, Date

4. Your Eligible Dependents (Member 3, 4, and 5)

DEPENDENTS FIRST NAME 3.)	M.I.	Last Name	Sex	Date of Birth

Social Security# (REQUIRED)	PCP ID# (see instructions)	Name of PCP
Is this your current PCP? Yes / No	FULL-TIME STUDENT AND AGED 19 OR OLDER ___	DISABLED AND AGED 26 OR OLDER ___

DEPENDENTS FIRST NAME 4.)	M.I.	Last Name	Sex	Date of Birth

Social Security# (REQUIRED)	PCP ID# (see instructions)	Name of PCP
Is this your current PCP? Yes/ No	FULL-TIME STUDENT AND AGED 19 OR OLDER ___	DISABLED AND AGED 26 OR OLDER ___

DEPENDENTS FIRST NAME 5.)	M.I.	Last Name	Sex	Date of Birth

Social Security# (REQUIRED)	PCP ID# (see instructions)	Name of PCP
Is this your current PCP? Yes/ No	FULL-TIME STUDENT AND AGED 19 OR OLDER ___	DISABLED AND AGED 26 OR OLDER ___

Please check if you are using separate forms for additional dependent children

Total# of dependents: _____

5. Personal Savings Account

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8. 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 certify or benefit booklet provided by my employer to understand my benefit 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 Confirm," Blue Cross and Blue Shield's notice of privacy practices.

EMPLOYEES SIGNATURE _____ Date _____ EMPLOYERS SIGNATURE _____ Date _____

If you have not indicated Y or N regarding your Medicare or other insurance status, you may receive a follow-up questionnaire.