

**Please Read the Instructions Before Filling Out This Form.**



**Enrollment and Change Form**

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

**MASSACHUSETTS**

Please mail to: P.O. Box 986001  
Boston, MA 02298 or fax to 1-617-246-7531

**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 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: _____
Three digit termination code							

**2. Yourself (Member 1)**

What products? <input type="checkbox"/> HMO - Network Blue New England <input type="checkbox"/> PPO - Blue Care Elect <input type="checkbox"/> HDHC - Access Blue New England Saver	Membership Type (Medical) <input type="checkbox"/> Individual <input type="checkbox"/> Family	<input type="checkbox"/> HSA - Health Savings Account (Pairs with the HDHC Plan Only) Calendar Year Contribution Goal: \$ _____			
First Name	M.I.	Last Name	Sex	Date of Birth	
Street Address/ P.O. Box #	Apt. #	City/ Town	State	Zip Code	
Home Phone ( )	Cell Phone ( )	Email			
Social Security # (REQUIRED) <sup>1</sup>	Other Insurance? <sup>2</sup> 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? <sup>2</sup> 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:  Spouse  Domestic Partner  Divorced Spouse (court ordered) Plan Type:  Medical  Dental

First Name	M.I.	Last Name	Sex	Date of Birth	
Social Security # (REQUIRED) <sup>1</sup>	Phone ( )	Other Insurance? <sup>1</sup> 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? <sup>2</sup> 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"/>			

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

Dependent's First Name 3.)	M.I.	Last Name	Sex	Date of Birth
Social Security # (REQUIRED) <sup>1</sup>	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 4.)	M.I.	Last Name	Sex	Date of Birth
Social Security # (REQUIRED) <sup>1</sup>	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 5.)	M.I.	Last Name	Sex	Date of Birth
Social Security # (REQUIRED) <sup>1</sup>	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 are using separate forms for additional dependent children  Total # of dependents: \_\_\_\_\_

**5. Not Applicable**

Blank space for "Not Applicable" section.

**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.