



Instructions

Section 1 To Be Filled Out by Your Employer

Your employer will fill out this section.

Type of Transaction—Check the box(es) that apply.

Subscriber Cancellation Codes—If the subscriber won't be continuing any Blue Cross Blue Shield coverage, carefully select one of the following and indicate the three-digit code on the form.

Code #	Reason for Canceling
041	<ul style="list-style-type: none"> • Changing to other health plan • Voluntary termination • COBRA cancellation (under 18 months or nonpayment)
042	<ul style="list-style-type: none"> • Over 65, changing to Group Medex[®] plan. (Requires Medicare A and B) • Over 65, changing to direct-pay Medex plan. (Requires Medicare A and B) • Over 65, changing to Medicare supplement other than Medex plans.
043	<ul style="list-style-type: none"> • Medicare (age =< 65)

Code #	Reason for Canceling
061	<ul style="list-style-type: none"> • Left employment • COBRA ending
063	<ul style="list-style-type: none"> • Transfer
064	<ul style="list-style-type: none"> • Cancellation as of original effective date
070	<ul style="list-style-type: none"> • Deceased
071	<ul style="list-style-type: none"> • Moved out of state (out of HMO service area)
076	<ul style="list-style-type: none"> • Military service

Note: If your subscribers are adding or dropping one benefit only (medical/dental), please indicate "add medical," "add dental," "cancel medical," or "cancel dental" in the "Remarks" section.

If your new hires are subject to a probationary period, please indicate the time frame in the "Remarks" section, as well as the qualifying events for new enrollees.

If a subscriber is being moved from an active group to a retiree group (within the same account), this is a transfer and not a termination. Please include the Medical or Dental Group # transferring to.

Cancellation date will be the first day of no coverage.

Qualifying Events—Remarks:

To assist in the enrollment process, please use check boxes or write in applicable information in the "Remarks" section of the form.

- Open Enrollment—Check this box for open enrollment.
- New Hire—Check this box for new hires to the company.
- COBRA—Check this box if person is continuing coverage under COBRA.
- Add Spouse—Check this box if spouse is being added. Ensure date of marriage is within approved retroactive period.
- Add Dependent—Check this box if adding any dependent.
- Loss of Coverage—Check this box if employee lost coverage through spouse or parent. Please include HIPAA Continuation of Coverage Letter from prior company/insurer.

If you have questions, contact your account service representative.

- Other—Check this box if change to family requires additional explanation. Please write in the reason for change (e.g., court order, adoption, New Dependent Law under HCR, legal guardianship, etc.). Include supporting documentation.

If you have questions, contact your account service representative.

Section 2 Yourself (Member 1)

Please fill in all information that applies to you. (REQUIRED)*

PCP ID#—If your health plan requires you to choose a primary care physician (PCP), please fill in this section. Write the PCP ID number (*not* the telephone number) of the doctor you have chosen to coordinate your health care. You'll find the doctor's PCP ID number in the provider directory for your health plan. If you need help choosing a PCP, please call our Physician Selection Service at 1-800-821-1388. A representative will be happy to help you select a doctor.

PCP ID number can be found at bluecrossma.com, select Find a Doctor.

Other Insurance—Do you have other health insurance or Medicare in addition to your Blue Cross Blue Shield plan? Please be sure to circle either Y (for *yes*) or N (for *no*) in the correct box. If you have other insurance, please write the name of the other insurance company and your member identification number.

To Add or Delete a Member—Are you adding or deleting a member under your existing membership? If yes, please fill in the areas in Sections 1 and 2. You may need help from your employer to fill in Section 1. Then, give us the details about the members you're adding or deleting in Section 3 and/or Section 4.

To Add or Delete a Member—Are you adding or deleting a member under your existing membership? If yes, please fill in the areas in Sections 1 and 2. You may need help from your employer to fill in Section 1. Then, give us the details about the members you're adding or deleting in Section 3 and/or Section 4.

Section 3 Member 2

If you choose a Family membership, please fill in this section if you want Member 2 to be covered. (REQUIRED)* (Note: Member 2 cannot be covered under an Individual membership.)

Other Insurance—Does your spouse or partner have other health insurance or Medicare? Please be sure to circle either Y (for *yes*) or N (for *no*) in the correct box. If your spouse or partner has other insurance, please write the name of the other insurance company and your member identification number.

Section 4 Your Eligible Dependents (Members 3, 4, and 5)

If you choose a Family membership, please fill in this section for all children or other eligible dependents you want to be covered. (REQUIRED)* (Note: Dependents cannot be covered under an Individual membership.)

If you have more than three dependents to be covered, please use additional Enrollment Forms as needed. Please indicate on the form that additional forms have been used and write in the total number of dependents you want to be enrolled.

Section 5 Signatures (Employer & Employee)

Employee: Please sign and date the application and return it to your employer. Employer: Please sign and date the application and return to Blue Cross Blue Shield of Massachusetts.

Please mail to:

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

* Under the Affordable Care Act, we are required to collect the Social Security number for you and any dependent enrolling in your plan.

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

Employer Name:	Requested Effective Date MM DD YYYY	Date of Hire MM DD YYYY
Current BCBS ID #, If Any	Current Medical Group #:	Medical Group # Transferring to:
	Current Dental Group #:	Current Dental Group # Transferring to:
Type of Transaction <input type="checkbox"/> ADD <input type="checkbox"/> CANCEL <input type="checkbox"/> CHANGE <input type="checkbox"/> TRANSFER Three-digit termination code	Remarks: (e.g., 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"/> Network Blue® New England \$1,000 Deductible <input type="checkbox"/> Dental Blue® Program 2	<input type="checkbox"/> Network Blue® New England \$2,000 Deductible <input type="checkbox"/> Medex® 2	<input type="checkbox"/> Blue Care Elect Preferred	Membership Type (Medical) <input type="checkbox"/> Individual <input type="checkbox"/> Family
			Membership Type (Dental) <input type="checkbox"/> Individual <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? 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
Social Security # (REQUIRED) ¹	Phone ()	Other Insurance? Y <input type="checkbox"/> / N <input type="checkbox"/>	Other Insurance Company Name
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? 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 (Members 3, 4, and 5)

Dependent's First Name (3.)	M.I.	Last Name	Sex
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 (4.)	M.I.	Last Name	Sex
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 (5.)	M.I.	Last Name	Sex
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: _____

5. Signatures (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.