

**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: M.I.I.A.
1 Winthrop Square, Boston, MA 02110

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"/> CHANGE <input type="checkbox"/> TRANSFER <input type="checkbox"/> CANCEL		(If canceling, please see instructions for three digit termination code.) <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		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 <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 <input type="checkbox"/> Saver Blue		<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"/> Group Medex or Managed Blue for Seniors <input type="checkbox"/> Blue Medicare Rx (Part D)		Kind of Membership (Medical) <input type="checkbox"/> Individual <input type="checkbox"/> Family <input type="checkbox"/> Two-Person	
Your First Name		M.I.		Last Name	
Street Address / P.O. Box #:		Apt. #:		City / Town	
Social Security #:		Telephone #: (area code) ()		Other Insurance?¹ Y <input type="checkbox"/> / N <input type="checkbox"/>	
PCP ID #: (see instructions)		Name of PCP		City / State	
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	
				Actively Working? 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"/> Divorced Spouse (court ordered)					
First Name		M.I.		Last Name	
Street Address / P.O. Box #:		Apt. #:		City / Town	
Social Security #:		Telephone #: (area code) ()		Other Insurance?¹ Y <input type="checkbox"/> / N <input type="checkbox"/>	
PCP ID #: (see instructions)		Name of PCP		City / State	
Is Member 2 covered by Medicare?¹ 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	
				Actively Working? Y <input type="checkbox"/> / N <input type="checkbox"/> If Retired, Date: _____	
1. 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 Eligible Dependents (Member 3, 4, and 5)					
Dependent's First Name 3.)		M.I.		Last Name	
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	
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	
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					
<input type="checkbox"/> HSA		Start Date:		End Date:	
<input type="checkbox"/> FSA - Health		Start Date:		End Date:	
<input type="checkbox"/> FSA - Dep.		Start Date:		End Date:	
				FSA GOAL AMOUNTS: (Please see instructions for maximum limits.)	
				Health \$:	
				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 _____	