

**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

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 LOCAL 641			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 #: 002283285		Dental Group # Transferring To	
Type of Transaction ☐ ADD ☐ CANCEL ☐ CHANGE Three digit termination code ☐ ☐ ☐ ☐ TRANSFER			Remarks: (i.e., qualifying event for a new add, change to family or other instruction) ☐ Open Enrollment ☐ Change to Family ☐ New Hire ☐ Add Spouse ☐ COBRA ☐ Add Dependent ☐ Loss of Coverage (HIPAA Continuation of Coverage Letter required) ☐ Other: _____						

2. Yourself (Member 1)

What products? ☐ Access Blue ☐ Blue Medicare Rx (Part D) ☐ Blue Choice ☐ Dental Blue ☐ Blue Choice New England ☐ HMO Blue		☐ HMO Blue New England ☐ Managed Blue for Seniors ☐ Medex (Group)		☐ Network Blue ☐ PPO ☐ Saver Blue		Membership Type (Medical) ☐ Individual ☐ Family		Membership Type (Dental) ☐ Individual ☐ Family			
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) ¹			Other Insurance? ² Y ☐ / N ☐		Other Insurance Company Name			Member Identification Number			
PCP ID # (see instructions) NOT APPLICABLE			Name of PCP NOT APPLICABLE			City / State NOT APPLICABLE			Is this your current PCP? Y ☐ / N ☐		
Are you covered by Medicare? ² Y ☐ / N ☐		Part A Effective Date MM DD YYYY		Part B Effective Date MM DD YYYY		Part D Effective Date MM DD YYYY		Medicare #		☐ 65+ ☐ Disabled ☐ ESRD If Retired, Date	
								Actively Working? Y ☐ / N ☐			

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) ¹			Phone ()		Other Insurance? ¹ Y ☐ / N ☐		Other Insurance Company Name			Member Identification Number		
PCP ID # (see instructions) NOT APPLICABLE			Name of PCP NOT APPLICABLE			City / State NOT APPLICABLE			Is this your current PCP? Y ☐ / N ☐			
Are you covered by Medicare? ² Y ☐ / N ☐		Part A Effective Date MM DD YYYY		Part B Effective Date MM DD YYYY		Part D Effective Date MM DD YYYY		Medicare #		☐ 65+ ☐ Disabled ☐ ESRD If Retired, Date		
								Actively Working? Y ☐ / N ☐				

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

Dependent's First Name			M.I.		Last Name			Sex		Date of Birth		
Social Security # (REQUIRED) ¹			PCP ID # (see instructions) NOT APPLICABLE			Name of PCP NOT APPLICABLE						
Is this your current PCP? Y ☐ / N ☐			Full-time student and aged 19 or older ☐			Disabled and aged 26 or older ☐			Plan Type: ☐ Medical ☐ Dental			
Dependent's First Name			M.I.		Last Name			Sex		Date of Birth		
Social Security # (REQUIRED) ¹			PCP ID # (see instructions) NOT APPLICABLE			Name of PCP NOT APPLICABLE						
Is this your current PCP? Y ☐ / N ☐			Full-time student and aged 19 or older ☐			Disabled and aged 26 or older ☐			Plan Type: ☐ Medical ☐ Dental			
Dependent's First Name			M.I.		Last Name			Sex		Date of Birth		
Social Security # (REQUIRED) ¹			PCP ID # (see instructions) NOT APPLICABLE			Name of PCP NOT APPLICABLE						
Is this your current PCP? Y ☐ / N ☐			Full-time student and aged 19 or older ☐			Disabled and aged 26 or older ☐			Plan Type: ☐ Medical ☐ Dental			
Dependent's First Name			M.I.		Last Name			Sex		Date of Birth		
Social Security # (REQUIRED) ¹			PCP ID # (see instructions) NOT APPLICABLE			Name of PCP NOT APPLICABLE						
Is this your current PCP? Y ☐ / N ☐			Full-time student and aged 19 or older ☐			Disabled and aged 26 or older ☐			Plan Type: ☐ Medical ☐ Dental			

Please check if you are using separate forms for additional dependent children ☐ Total # of dependents: _____

5. Personal Savings Account

☐ HSA: Health Savings Account	Start Date	End Date	FSA Goal Amount (Please see instructions for limits.): \$
☐ FSA: Health Flexible Spending Account	Start Date	End Date	Health: \$
☐ FSA: Dependent Care Reimbursement Account	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 _____

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.