

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: BCBSMA, P.O. Box 986001, Boston, MA 02298 or fax 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"/> 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"/> Change to Family	<input type="checkbox"/> Loss of Coverage (HIPAA Continuation of Coverage Letter Required)	
		<input type="checkbox"/> New Hire	<input type="checkbox"/> Add Spouse		
		<input type="checkbox"/> COBRA	<input type="checkbox"/> Add Dependent	<input type="checkbox"/> Other _____	

2. Tell Us About Yourself (Member 1)

What Products are you selecting?	<input type="checkbox"/> Dental Dctle <input type="checkbox"/> F gpcnJ ki j				Kind of Membership (Dental) <input type="checkbox"/> Individual <input type="checkbox"/> Family	
Your First Name		M.I.	Last Name		Sex	Date of Birth
Street Address / P.O. Box #:		Apt. #:	City / Town		State	Zip Code
Social Security #:	Telephone #: (area code) ()	Other Insurance? * Y <input type="checkbox"/> / N <input type="checkbox"/>	Other Insurance Company Name		City / State	

3. Tell Us About (Member 2) Please check one: Spouse Divorced Spouse (court ordered)

Member 2's First Name		M.I.	Last Name		Sex	Date of Birth
Street Address / P.O. Box #:		Apt. #:	City / Town		State	Zip Code
Social Security #:	Telephone #: (area code) ()	Other Insurance? * Y <input type="checkbox"/> / N <input type="checkbox"/>	Other Insurance Company Name		City / State	

4. Tell Us About Your Dependents (Member 3, 4, and 5)

Dependent's First Name 3.)		M.I.	Last Name		Sex	Full-time student? Age 19 or Over Y <input type="checkbox"/> / N <input type="checkbox"/>
Social Security #:	Date of Birth					<input type="checkbox"/>
Dependent's First Name 4.)		M.I.	Last Name		Sex	Full-time student? Age 19 or Over Y <input type="checkbox"/> / N <input type="checkbox"/>
Social Security #:	Date of Birth					<input type="checkbox"/>
Dependent's First Name 5.)		M.I.	Last Name		Sex	Full-time student? Age 19 or Over Y <input type="checkbox"/> / N <input type="checkbox"/>
Social Security #:	Date of Birth					<input type="checkbox"/>

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

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
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