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

MIIA Massachusetts Based Member Driven

NEW FAMILY APPLICATIONS REQUIRE A MARRIAGE CERTIFICATE AND CHILDRENS BIRTH CERTIFICATES

1. To Be Filled Out by Your Employer

Company Name	Current Medical Group #:	Medical Group #, Transfering 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
❒ ADD ❒ CANCEL
❒ CHANGE Three digit
❒ TRANSFER termination code ☐☐☐

Remarks: (i.e., qualifying event for a new add, change to family or other instruction)

❒ Open Enrollment
❒ New Hire
❒ COBRA

Change to Family
❒ Add Spouse
❒ Add Dependent

❒ Loss of Coverage (HIPAA Continuation of Coverage Letter required)
❒ Other: ____________________

2. Yourself (Member 1)

What products?
❒ HMO Blue New England
❒ Dental Blue High
❒ Blue Choice
Access Blue New England
❒ DentalBlueLow
Network Blue NE Deductible

Membership Type (Medical) ❒ Individual ❒ Family
Membership Type (Dental) ❒ Individual ❒ Family

Your First Name	M.I.	Last Name	Sex	Date of Birth

Street Address/ P.O. Box #	Apt. #	City/ Town	State	Zip Code

Phone ( )

Social Security # (REQUIRED)[1]	Other Insurance?[2] Y ❒ / N ❒	Other Insurance Company Name	Member Identification Number

PCP ID # (see instructions)	Name of PCP	City / State	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 # Actively Working? Y ❒ / N ❒	❒ 65+ ❒ Disabled ❒ ESRD If Retired, Date

3. Member 2

Please Check One: ❒ Spouse ❒ 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)	Name of PCP	City / State	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 # Actively Working? Y ❒ / N ❒	❒ 65+ ❒ Disabled ❒ ESRD If Retired, Date

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)[1]	PCP ID # (see instructions)	Name of PCP

Is this your current PCP? Y ❒ / N ❒ | Disabled and aged 26 or older ❒ | Plan Type: ❒ Medical ❒ Dental

Dependent's First Name 4.)	M.I.	Last Name	Sex	Date of Birth

Social Security # (REQUIRED)[1]	PCP ID # (see instructions)	Name of PCP

Is this your current PCP? Y ❒ / N ❒ | Disabled and aged 26 or older ❒ | Plan Type: ❒ Medical ❒ Dental

Dependent's First Name 5.)	M.I.	Last Name	Sex	Date of Birth

Social Security # (REQUIRED)[1]	PCP ID # (see instructions)	Name of PCP

Is this your current PCP? Y ❒ / N ❒ | 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: ____________

☐ HSA: Health Savings Account	start date		Goal Amount
☐ **HSA ACCOUNT IS ONLY FOR**			
☐ **ACCESS BLUE ENROLLMENT**			

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 Licence of the Blue Cross and Blue Shield Association.