

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

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 #, 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"/> CANCEL <input type="checkbox"/> CHANGE Three digit termination code <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> TRANSFER		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"/> Other: _____ <input type="checkbox"/> COBRA <input type="checkbox"/> Add Dependent			
2. Yourself (Member 1)					
What products?		<input type="checkbox"/> HMO Blue New England <input type="checkbox"/> Dental Blue High <input type="checkbox"/> Blue Choice	<input type="checkbox"/> Access Blue New England <input type="checkbox"/> DentaBlueLow XXXXXXXX <input type="checkbox"/> Medex (Group)	Membership Type (Medical) <input type="checkbox"/> Family	Membership Type (Dental) <input type="checkbox"/> Individual <input type="checkbox"/> Family
Your First Name		M.I.	Last Name		Sex
Street Address/ P.O. Box #		Apt. #	City/ Town		State
Phone ()					
Social Security # (REQUIRED) ¹		Other Insurance? ² Y <input type="checkbox"/> / N <input type="checkbox"/>	Other Insurance Company Name		Member Identification Number
PCP ID # (see instructions)		Name of PCP			City / State
Are you covered by Medicare? ² 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? ¹ Y <input type="checkbox"/> / N <input type="checkbox"/>		Other Insurance Company Name
PCP ID # (see instructions)		Name of PCP			City / State
Are you covered by Medicare? ² 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 (Member 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"/>		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"/>		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"/>		Disabled and aged 26 or older <input type="checkbox"/>			Plan Type: <input type="checkbox"/> Medical <input type="checkbox"/> Dental
Please check if you are using separate forms for additional dependent children <input type="checkbox"/>				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 _____

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.