



MASSACHUSETTS

# Thank you for choosing a Blue Cross Blue Shield plan.

Please take a few minutes to help us set up your membership by filling out the attached enrollment form.

## Before You Begin

Please carefully read the instructions below.

**For members of HMO Blue,<sup>®</sup> Network Blue,<sup>®</sup> Blue Choice,<sup>®</sup> HMO Blue New England,<sup>SM</sup> or Blue Choice New England<sup>SM</sup>:** You're required to choose a primary care physician (PCP) when you enroll. Please choose a PCP from your plan's provider directory. Be sure to read "PCP ID #" in Section 2. List your PCP choice on your enrollment form. The PCP ID number can also be found by visiting [bluecrossma.com](http://bluecrossma.com) and selecting **Find a Doctor**.

**For Access Blue<sup>SM</sup> Members:** Although you're not required to choose a PCP, we recommend you choose one by following the instructions in Section 2 on the back of this page.

**Important:** Are you covered by Medicare or other insurance? We need to know if you or any family member listed have Medicare and/or other insurance in addition to your Blue Cross Blue Shield of Massachusetts plan. Please be sure to check either Y (for yes) or N (for no) in the correct box. This information will help us accurately coordinate your benefits. Please follow the instructions in Sections 2 and 3.

Please print two copies of your completed application. Keep one for your records and give the other to your employer to sign and mail to Blue Cross Blue Shield of Massachusetts. In order to complete your enrollment request, your employer is required to sign the application.

**Special Instructions for Student Coverage:** If you're seeking coverage for a full-time student dependent over age 19, you may need to fill out a Student Certificate form. Check with your employer to see if this coverage is available.

**Blue Cross Blue Shield of Massachusetts**  
**P.O. Box 986001**  
**Boston, MA 02298**  
**Fax: 1-617-246-7531**

# Instructions

## Section 1 To Be Filled Out By Your Employer

Your employer will fill out this section.

**Type of Transaction**—Check the box(es) that apply.

**Subscriber Cancellation Codes.** If the subscriber won't be continuing any Blue Cross Blue Shield coverage, carefully select one of the following and indicate the three-digit code on the form.

Code #	Reason for Canceling	Code #	Reason for Canceling
041	<ul style="list-style-type: none"> <li>• Changing to other health plan</li> <li>• Voluntary termination</li> <li>• COBRA cancellation (under 18 months or nonpayment)</li> </ul>	061	<ul style="list-style-type: none"> <li>• Left employment</li> <li>• COBRA ending</li> </ul>
042	<ul style="list-style-type: none"> <li>• Over 65, changing to Group Medex® plan. (Requires Medicare A and B)</li> <li>• Over 65, changing to direct-pay Medex plan. (Requires Medicare A and B)</li> <li>• Over 65, changing to Medicare supplement other than Medex plans.</li> </ul>	063	• Transfer
043	• Medicare (age =< 65)	064	• Cancellation as of original effective date
		070	• Deceased
		071	• Moved out of state (out of HMO service area)
		076	• Military service

**Note:** If your subscribers are adding or dropping one benefit only (medical/dental), please indicate “add medical,” “add dental,” “cancel medical,” or “cancel dental” in the “Remarks” section.

If your new hires are subject to a probationary period, please indicate the time frame in the “Remarks” section, as well as the qualifying events for new enrollees.

If a subscriber is being moved from an active group to a retiree group (within the same account), this is a transfer and not a termination. Please include the Medical or Dental Group # transferring to.

Cancellation date will be the first day of no coverage.

### Qualifying Events—Remarks:

To assist in the enrollment process, please use check boxes or write in applicable information in the “Remarks” section of the form.

- Open Enrollment—Check this box for open enrollment.
- New Hire—Check this box for new hires to the company.
- COBRA—Check this box if person is continuing coverage under COBRA.
- Add Spouse—Check this box if spouse is being added. Ensure date of marriage is within approved retroactive period.
- Add Dependent—Check this box if adding any dependent.
- Loss of Coverage—Check this box if employee lost coverage through spouse or parent. Please include HIPAA Continuous of Coverage Letter from prior company/insurer. If you have questions, contact your account service representative.
- Other—Check this box if change to family requires additional explanation. Please write in the reason for change (e.g., court order, adoption, New Dependent Law under HCR, legal guardianship, etc.). Include supporting documentation. If you have questions, contact your account service representative.

## Section 2 Yourself (Member 1)

Please fill in all information that applies to you. (REQUIRED)\*

**PCP ID#**—If your health plan requires you to choose a primary care physician (PCP), please fill in this section. Write the PCP ID number (*not* the telephone number) of the doctor you have chosen to coordinate your health care. You'll find the doctor's PCP ID number in the provider directory for your health plan. If you need help choosing a PCP, please call our Physician Selection Service at 1-800-821-1388. A representative will be happy to help you select a doctor. PCP ID number can be found at [bluecrossma.com](http://bluecrossma.com), select **Find a Doctor**.

**Other Insurance**—Do you have other health insurance or Medicare in addition to your Blue Cross Blue Shield plan? Please be sure to circle either **Y** (for *yes*) or **N** (for *no*) in the correct box. If you have other insurance, please write the name of the other insurance company and your member identification number.

**To Add or Delete a Member**—Are you adding or deleting a member under your existing membership? If yes, please fill in the areas in Sections 1 and 2. You may need help from your employer to fill in Section 1. Then, give us the details about the members you're adding or deleting in Section 3 and/or Section 4.

## Section 3 Member 2

If you choose a **Family** membership, please fill in this section if you want Member 2 to be covered. (REQUIRED)\* (Note: Member 2 cannot be covered under an **Individual** membership.)

**Other Insurance**—Does your spouse have other health insurance or Medicare? Please be sure to circle either **Y** (for *yes*) or **N** (for *no*) in the correct box. If your spouse or partner has other insurance, please write the name of the other insurance company and your member identification number.

## Section 4 Your Eligible Dependents (Members 3, 4, and 5)

If you choose a **Family** membership, please fill in this section for all children or other eligible dependents you want to be covered. (REQUIRED)\* (Note: dependents cannot be covered under an **Individual** membership.)

If you have more than three dependents to be covered, please use additional Enrollment Forms as needed. Please indicate on the form that additional forms have been used and write in the total number of dependents you want to be enrolled.

## Section 5 Personal Savings Account

Your employer may have chosen to offer a personal savings account alongside your medical offering. Please consult your open enrollment materials and/or your HR department to determine if this applies to you.

**For each option:**

**Start Date:** Your start date will be considered established for tax purposes as of the start date of your medical plan, provided that you have signed, dated, and submitted the completed application for these accounts on or before that date.

**End Date:** Your end date is the date you choose to stop deposits into the selected financial account. If you have any questions, please see your employer.

**Note:** If you are transferring from one medical/dental plan to another plan, please complete Section 5 of the Enrollment and Change Form to let us know that you will be continuing your personal savings account.

## Section 6 Signatures (Employer & Employee)

**Employee:** Please sign and date the application and return it to your employer. **Employer:** Please sign and date the application and return to Blue Cross Blue Shield of Massachusetts. Please mail to:

P.O. Box 986001  
Boston, MA 02298  
or fax to 1-617-246-7531

\* Under the Affordable Care Act, we are required to collect the Social Security number for you and any dependent enrolling in your plan.

**Please Read the Instructions Before Filling Out This Form.**



**Enrollment and Change Form**

Please **TYPE OR PRINT CLEARLY** using blue or black ink to avoid coverage delay or type in information

**MASSACHUSETTS**

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		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 <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"/> New Hire <input type="checkbox"/> COBRA			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. Yourself (Member 1)**

What products? <input type="checkbox"/> Access Blue <input type="checkbox"/> Blue Choice <input type="checkbox"/> Blue Choice New England	<input type="checkbox"/> Blue Medicare Rx (Part D) <input type="checkbox"/> Dental Blue <input type="checkbox"/> HMO Blue	<input type="checkbox"/> HMO Blue New England <input type="checkbox"/> Managed Blue for Seniors <input type="checkbox"/> Medex (Group)	<input type="checkbox"/> Network Blue <input type="checkbox"/> PPO <input type="checkbox"/> Saver Blue	Membership Type (Medical) <input type="checkbox"/> Individual <input type="checkbox"/> Family	Membership Type (Dental) <input type="checkbox"/> Individual <input type="checkbox"/> 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) <sup>1</sup>	Other Insurance? <sup>2</sup> Y <input type="checkbox"/> / N <input type="checkbox"/>	Other Insurance Company Name		Member Identification Number	
PCP ID # (see instructions)	Name of PCP	City / State			Is this your current PCP? Y <input type="checkbox"/> / N <input type="checkbox"/>
Are you covered by Medicare? <sup>2</sup> 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

**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) <sup>1</sup>	Phone ( )	Other Insurance? <sup>1</sup> Y <input type="checkbox"/> / N <input type="checkbox"/>	Other Insurance Company Name	Member Identification Number	
PCP ID # (see instructions)	Name of PCP	City / State			Is this your current PCP? Y <input type="checkbox"/> / N <input type="checkbox"/>
Are you covered by Medicare? <sup>2</sup> 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

**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) <sup>1</sup>	PCP ID # (see instructions)	Name of PCP		Is this your current PCP? Y <input type="checkbox"/> / N <input type="checkbox"/>	
Is this your current PCP? Y <input type="checkbox"/> / N <input type="checkbox"/>		Full-time student and aged 19 or older <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	Date of Birth
Social Security # (REQUIRED) <sup>1</sup>	PCP ID # (see instructions)	Name of PCP		Is this your current PCP? Y <input type="checkbox"/> / N <input type="checkbox"/>	
Is this your current PCP? Y <input type="checkbox"/> / N <input type="checkbox"/>		Full-time student and aged 19 or older <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	Date of Birth
Social Security # (REQUIRED) <sup>1</sup>	PCP ID # (see instructions)	Name of PCP		Is this your current PCP? Y <input type="checkbox"/> / N <input type="checkbox"/>	
Is this your current PCP? Y <input type="checkbox"/> / N <input type="checkbox"/>		Full-time student and aged 19 or older <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  Total # of dependents: \_\_\_\_\_

**5. Personal Savings Account**

<input type="checkbox"/> HSA: Health Savings Account	Start Date	End Date	FSA Goal Amount (Please see instructions for limits.): \$
<input type="checkbox"/> FSA: Health Flexible Spending Account	Start Date	End Date	Health: \$
<input type="checkbox"/> 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.