Read the instructions before filling out this form.

Please TYPE OR PRINT CLEARLY, using blue or black ink, to avoid coverage delay

MASSACHUSETTS

ENROLLMENT AND CHANGE FORM

1. To be filled out by your employer

Company name	Current medical group #:	Medical group # transferring to:
City of Brockton		
❒ School active ❒ School retiree ❒ City active ❒ City retiree		

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: (e.g., 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?
❒ Network Blue® New England
❒ Dental Blue® Freedom
❒ Blue Care Elect
❒ Retiree Dental Blue Freedom
❒ MEDEX 2®′

Membership type (medical) ❒ Individual ❒ Family

Membership type (dental) ❒ Individual ❒ Family

First name	M.I.	Last name	Gender	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? 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

Check One: ❒ Spouse ❒ Divorced spouse (court ordered)

Plan Type: ❒ Medical ❒ Dental

First name	M.I.	Last name	Gender	Date of birth

Social Security # (REQUIRED)[1]	Phone ( )	Other insurance? Y ❒ / N ❒	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 (Members 3, 4, and 5)

Dependent's first name 3.)	M.I.	Last name	Gender	Date of birth

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

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 4.)	M.I.	Last name	Gender	Date of birth

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

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 5.)	M.I.	Last name	Gender	Date of birth

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

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

Check if you're using separate forms for additional dependent children ❒

Total # of dependents: _____

5. 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're required to collect the Social Security number for you and any dependent(s) enrolling in your plan.