BlueQuote
QUOTING, SIMPLIFIED.

Blue Cross Blue Shield of Massachusetts

Enrollment and Change Form

Please mail to: BCBSMA, P.O. Box 9145, North Quincy, MA 02171-9145

Please Read The Instructions Before Filling Out This Form.

1. To Be Filled Out by Your Employer

Company Name	Current Medical Group	Medical Group Transferring To:

Current BCBS ID Number, if any	Requested Effective Date (MM DD YYYY)	Date of Hire (MM DD YYYY)	Initial Eligibility Date (MM DD YYYY)	Current Dental Group	Dental Group Transferring To:

Type of Transaction (Please fill in termination code, see instructions.)

Add X Change X Cancel

Remarks: (i.e., qualifying event for anew add, change to family, or further instruction)

2. Tell Us About Yourself (Member 1)

What product are you selecting?

HMO Blue	Network Blue	Blue Choice	Dental Blue	HMO Blue New England	Blue Choice New England	PPO	Other (write name of Plan)
X	X	X	X	X	X	X	X

Kind of Membership (Medical): Individual X Family X

Kind of Membership (Dental): Individual X Family X

Your First Name	M.I.	Last Name	Sex	Date of Birth (MM DD YYYY)

Street Address/P.O. Box No.	Apt. No.	City/Town	State	Zip Code

Social Security No.	Home Telephone No. (including area code)	Other Insurance?* Y/N	Other Insurance Company Name	City/State

Name of PCP	City/State	PCP ID Number	Is this your current PCP? Mark X, if yes. X

Are You or Anyone Listed Below Covered by Medicare?* Y/N	Part A Effective Date (MM DD YYYY)	Part B Effective Date (MM DD YYYY)	Medicare No. X 65+ X disabled X ESRD	Actively Working Y/N Retired Y/N If yes, date:

**If you have not indicated yes or no regarding your Medicare or other insurance status, you may receive a follow-up questionnaire.*

3. Tell Us About Your Spouse (Member 2)

Spouse's First Name	M.I.	Spouse's Last Name	Sex	Date of Birth (MM DD YYYY)

Social Security No.	Home Telephone No. (including area code)	Other Insurance?* Y/N	Other Insurance Company Name	City/State

Name of PCP	City/State	PCP ID Number	Is this your current PCP? Mark X, if yes. X

Part A Effective Date (MM DD YYYY)	Part B Effective Date (MM DD YYYY)	Medicare No. X 65+ X disabled X ESRD	Actively Working Y/N Retired Y/N If yes, date:

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

Child's First Name	M.I.	Child's Last Name	Sex	Full Time Student? Age 19 or over Y/N

Date of Birth (MM DD YYYY)	Social Security No.	PCP ID Number	Name of PCP	Is this your current PCP? Mark X , if yes. X

Child's First Name	M.I.	Child's Last Name	Sex	Full Time Student? Age 19 or over Y/N

Date of Birth (MM DD YYYY)	Social Security No.	PCP ID Number	Name of PCP	Is this your current PCP? Mark X , if yes. X

Child's First Name	M.I.	Child's Last Name	Sex	Full Time Student? Age 19 or over Y/N

Date of Birth (MM DD YYYY)	Social Security No.	PCP ID Number	Name of PCP	Is this your current PCP? Mark X , if yes. X

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 authorize Blue Cross and Blue Shield to obtain medical records or information from the Social Security Administration, Medicare contractors, other health care programs, insurers, or any government agency to verify eligibility, claims payment information or properly coordinate benefits.

Employee's Signature ____________ Date ____________ Employer's Signature ____________ Date ____________