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

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MIIA Nonprofit Locally based Member driven. Serving Massachusetts communities since 1982

# Enrollment and Change Form

## 1. To Be Filled Out by Your Employer

| Company Name **Chelmsford** Department: School | Current Medical Group #: | Medical Group # Transfering: |
|---|---|---|

| 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 termination code ☐☐☐
❒ TRANSFER

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? **Select Medical Plan** **Select Dental Plan** | Membership Type (Medical) | Membership Type (Dental) |
|---|---|---|

| 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)[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 ❒ 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 | Sex | 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 | Sex | 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

Please check if you are using separate forms for additional dependent children ❒ Total # of dependents: _____

## 5. Personal Savings Account

| | Start Date | End Date | FSA Goal Amount (Please see instructions for limits.): $ |
|---|---|---|---|
| ☐ HSA: Health Savings Account | | | |
| ☐ FSA: Health Flexible Spending Account | Start Date | End Date | Health: $ |
| ☐ 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.