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

Read the instructions below carefully.

For members of HMO Blue®, Network Blue®, Blue Choice®, HMO Blue New England℠, or Blue Choice New England℠: You're required to choose a primary care provider (PCP) when you enroll. Choose a PCP from your plan's provider directory. Be sure to read the "PCP ID #" in Section 2. List your PCP choice on your enrollment form. You can also find the PCP ID number by visiting **bluecrossma.org** and selecting **Find a Doctor.**

For Access Blue℠ Members:
Although you're not required to choose a PCP, we recommend that 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 has Medicare and/or other insurance in addition to your Blue Cross Blue Shield of Massachusetts plan. Be sure to check either **Y** (for yes) or **N** (for no) in the correct box. This information will help us coordinate your benefits accurately. Follow the instructions in Sections 2 and 3.

Print two copies of your completed application. Keep one for your records and give the other to MIIA to sign and mail to Blue Cross Blue Shield of Massachusetts. Your employer is required to sign the application to complete your enrollment request.

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

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Instructions

Section 1 To Be Filled Out by Your Employer

Your employer will fill out this section.

Type of Transaction—Check one or more boxes that apply.

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

Code #	*Reason for Canceling*
041	• *Changing to other health plan* • *Voluntary termination* • *COBRA cancellation (under 18 months or nonpayment)*
042	• *65 and over, changing to Group Medex® plan. (Requires Medicare A and B)* • *65 and over, changing to direct-pay Medex plan. (Requires Medicare A and B)* • *65 and over, changing to Medicare supplement other than Medex plans.*
043	• *Medicare (age = 65 and over)*

Code #	*Reason for Canceling*
061	• *Left employment* • *COBRA ending*
063	• *Transfer*
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, 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. Include the new Medical or Dental Group #.

Cancellation date will be the first day of no coverage.

Qualifying Events*—Remarks:*

To assist in the enrollment process, use check boxes or write the 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. 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. 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)

*Fill in all information that applies to you. (REQUIRED)**

PCP ID#*—If your health plan requires you to choose a primary care provider (PCP), 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, call our Physician Selection Service at 1-800-821-1388. A representative will help you select a provider. You can find the PCP ID number at bluecrossma.org, select Find a Doctor.*

Gender*—Enter M for male, F for female, or NB for non-binary*

Other Insurance*—Do you have other health insurance or Medicare in addition to your Blue Cross Blue Shield plan? Be sure to circle either Y (for yes) or N (for no) in the correct box. If you have other insurance, 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, 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, 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? Be sure to circle either Y (for yes) or N (for no) in the correct box. If your spouse or partner has other insurance, 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, 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, use additional Enrollment Forms as needed. 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. 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, see your employer.*

Note: *If you're transferring from one medical/dental plan to another plan, 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: *Sign and date the application and return it to your employer.* ***Employer:*** *Sign and date the application and return it 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're 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.

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:
Town of Westminster		

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 (HMO) ☐ Access Blue New England Saver
☐ Blue Care Elect Preferred (PPO) ☐ Blue Care Elect Saver
☐ Blue Choice New England (POS) ☐ Dental Blue Freedom ☐ MEDEX

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 #	☐ 65+ ☐ Disabled ☐ ESRD If Retired, Date
				Actively Working? Y ☐ / N ☐	

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 ☐	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 #	☐ 65+ ☐ Disabled ☐ ESRD If Retired, Date
				Actively Working? Y ☐ / N ☐	

4. Your Eligible Dependents (Member 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 ☐ — Disable d 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. Personal Savings Account

	Start Date	End Date	FSA Goal Amount (see instructions for limits.): $
☐ HSA: Health Savings Account			
☐ FSA: Health Flexible Spending Account	Start Date	End Date	Health: $
☐ DCFSA: Dependent Care Flexible Spending 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're required to collect the Social Security number for you and any dependent enrolling in your plan.