- Application -

MASSACHUSETTS

MIIA

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,® Network Blue,® Blue Choice,® HMO Blue New England,℠ or Blue Choice New England℠: 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** and selecting **Find a Doctor**.

For Access BlueSM 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 MIIA 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.

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

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Enrollment and Change Form

1. To Be Filled Out by Your Employer

Company Name	Current Medical Group #:	Medical Group # Transfering 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
❒ 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? ❒ Access Blue ❒ Blue Choice ❒ Blue Choice New England ❒ Blue Medicare Rx (Part D) ❒ Dental Blue ❒ HMO Blue ❒ HMO Blue New England ❒ Managed Blue for Seniors ❒ Medex (Group) ❒ Network Blue ❒ PPO ❒ Saver Blue

Membership Type (Medical) ❒ Individual ❒ Family

Membership Type (Dental) ❒ Individual ❒ 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)[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 #	❒ 65+ ❒ Disabled ❒ ESRD
				Actively Working? Y ❒ / N ❒	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)[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 #	❒ 65+ ❒ Disabled ❒ ESRD
				Actively Working? Y ❒ / N ❒	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	
☐ HSA: Health Savings Account			FSA Goal Amount (Please see instructions for limits.): $
☐ FSA: Health Flexible Spending Account			Health: $
☐ FSA: Dependent Care Reimbursement Account			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.