MASSACHUSETTS

BLUE 20/20
APPLICATION / CHANGE FORM

Please check one, then complete form below:

❑ **New Enrollee:** Complete A, C, D, and E.	❑ **Change Request:** Complete Sections A, B, and all other applicable sections. Plan changes can only be made at Open Enrollment or due to a qualifying event.	❑ **Termination:** Plan termination for active employees can only be made at Open Enrollment or due to a qualifying event.

A. Employee Information

Last Name:	**First Name:**	**MI:**
Social Security Number:	**Date of Birth** (mm/dd/yyyy):	**Gender:**
Mailing Address:	**City:**	**State:** / **ZIP Code:**
Phone Number:	**Email Address:**	
Name of Employer:		
Dept./Division:	**Date of Hire** (mm/dd/yyyy):	**Effective Date** (mm/dd/yyyy):

B. If Making a Change from Previous Enrollment

Check All That Apply:

- ❑ Name Change
- ❑ Employee SSN Correction
- ❑ Add/Remove Dependent
- ❑ Address/Telephone Number Change
- ❑ Date of Birth Correction
- ❑ Late Enrollee
- ❑ Other

Add Dependent(s):	**Date of Occurrence** (mm/dd/yyyy):
❑ Marriage	_____
❑ Newborn (up to age 1)	_____
❑ Adoption	_____
❑ Court Order	_____
❑ Loss of Coverage	_____
❑ Other	_____
❑ **Remove Dependent(s)**	_____

Reason: _____

_____

Reinstate Coverage Date (mm/dd/yyyy):

_____

Reason: _____

_____

_____

Terminate Coverage Date (mm/dd/yyyy):

_____

Reason: _____

_____

_____

Blue Cross Blue Shield of Massachusetts is an Independent Licensee of the Blue Cross and Blue Shield Association.

C. Coverage Selection

Options Selected: ❑ Employee ❑ Employee plus spouse ❑ Employee plus one or more children ❑ Family

D. Family Information (Complete for each family member requesting a change in coverage.*)

Select Option	Name (First, MI, Last Name)	Date of Birth (mm/dd/yyyy)	Relationship	Gender
❑ Add ❑ Remove				
❑ Add ❑ Remove				
❑ Add ❑ Remove				
❑ Add ❑ Remove				
❑ Add ❑ Remove				
❑ Add ❑ Remove				
❑ Add ❑ Remove				

***Enrollment isn't guaranteed.**

Eligibility Notes:

1. Employees are eligible for coverage if they meet the definition of an eligible employee as defined by their employer and Blue Cross Blue Shield of Massachusetts.
2. Domestic partners are eligible for coverage if they meet the definition of a domestic partner and if allowed by the employer.
3. Dependent children are eligible for coverage up to age 26.

Please complete this form, keep a copy for your records, and return the original to:

Blue 20/20 Enrollment Department
c/o EBPA
37 Industrial Drive, Suite E
Exeter, NH 03833
Email: Blue2020enrollmentservices@ebpabenefits.com
FAX: 1-603-773-4420

E. Statement of Understanding

The information here is complete and true. I understand that Blue Cross and Blue Shield of Massachusetts 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 vision plan.

Employee Signature	**Date** (mm/dd/yyyy):

Blue Cross Blue Shield of Massachusetts complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex, sexual orientation, or gender identity.

ATTENTION: If you don't speak English, language assistance services, free of charge, are available to you. Call Member Service at the number on your ID card (TTY: 711).

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia con el idioma. Llame al número de Servicio al Cliente que figura en su tarjeta de identificación (TTY: 711).

ATENÇÃO: Se fala português, são-lhe disponibilizados gratuitamente serviços de assistência de idiomas. Telefone para os Serviços aos Membros, através do número no seu cartão ID (TTY: 711).

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