

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



Enrollment and Change Form

1. To Be Filled Out by Your Employer					
Company Name Town of Avon		Current Medical Group #: 4035072		Medical Group #, Transferring 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		New Hire ☐ Open Enrollment ☐ Change to Family ☐ New Hire ☐ Add Spouse ☐ COBRA ☐ Add Dependent ☐ Loss of Coverage (HIPAA Continuation of Coverage Letter required) ☐ Other: _____			
2. Yourself (Member 1)					
What products? ☐ HMO Blue New England ☐ Dental Blue ☐ HMO Blue Select		☐ Managed Blue for Seniors ☐ Medex (Group)		Membership Type (Medical) ☐ Individual ☐ 2 person ☐ Family	
Your First Name		M.I.	Last Name	Sex	Date of Birth
Street Address/ P.O. Box #		Apt. #	City/ Town	State MA	Zip Code
Phone ()					
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 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 #	☐ 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 ☐	
Is this your current PCP? Y ☐ / N ☐		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 ☐	
Is this your current PCP? Y ☐ / N ☐		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 ☐	
Is this your current PCP? Y ☐ / N ☐		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					
☐ HSA: Health Savings Account		Start Date	End Date	FSA Goal Amount (Please see instructions for limits.): \$	
☐ 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.

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

RESET FORM