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

MIIA Nonprofit Locally based Member driven
Serving Massachusetts communities since 1982

Enrollment and Change Form

1. Employer Section

Account Name: **Chelmsford**	Current Medical Group #:	Medical Group # Transfering To:

Department:	Requested Effective Date:	Date of Hire:	Current Dental Group #:	Dental Group # Transferring To:

Type of Transaction:
❒ ADD ❒ CANCEL
❒ CHANGE Three digit termination code ☐☐☐
❒ TRANSFER

Remarks:

❒ Open Enrollment
❒ New Hire
❒ COBRA

Change to Family
❒ Add Spouse
❒ Add Dependent

❒ Loss of Coverage
❒ Other: _____

2. Subscriber (You)

☐ Network Blue NE (HMO) ☐ Blue Care Elect (PPO)
☐ Network Blue Select (HMO)

Please note: Medex and MAPD plans each require different application forms.

☐ Dental Blue Low
☐ Dental Blue High

Coverage Type (Medical) ❒ Individual ❒ Family

Coverage 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)	PCP ID #	Name of PCP	PCP City

3. Spouse

First Name	M.I.	Last Name	Sex	Date of Birth

Social Security # (REQUIRED)	PCP ID #	Name of PCP	PCP City

4. Dependent Children

1.) First Name	M.I.	Last Name	Sex	Date of Birth

Social Security # (REQUIRED)	PCP ID #	Name of PCP	PCP City

2.) First Name	M.I.	Last Name	Sex	Date of Birth

Social Security # (REQUIRED)	PCP ID #	Name of PCP	PCP City

3.) First Name	M.I.	Last Name	Sex	Date of Birth

Social Security # (REQUIRED)	PCP ID #	Name of PCP	PCP City

4.) First Name	M.I.	Last Name	Sex	Date of Birth

Social Security # (REQUIRED)	PCP ID #	Name of PCP	PCP City

5.) First Name	M.I.	Last Name	Sex	Date of Birth

Social Security # (REQUIRED)	PCP ID #	Name of PCP	PCP City

6.) First Name	M.I.	Last Name	Sex	Date of Birth

Social Security # (REQUIRED)	PCP ID #	Name of PCP	PCP City

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.