MASSACHUSETTS | MIIA Nonprofit Locally based Member driven
Serving Massachusetts' communities since 1982

# 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 provider (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. 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 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 accurately coordinate your benefits. Please 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. To complete your enrollment request, your employer is required to sign the application.

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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# Instructions

## Section 1 To Be Filled Out by Your Employer

**Your employer will fill out this section.**

**Type of Transaction—**Check the box(es) that apply.

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

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

| Code # | Reason for Canceling |
|---|---|
| 061 | • Left employment<br>• 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, please 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. Please 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, please use check boxes or write in 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. Please 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. Please 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)

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

**PCP ID#—**If your health plan requires you to choose a primary care provider (PCP), please 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**.

**Other Insurance**—Do you have other health insurance or Medicare in addition to your Blue Cross Blue Shield plan? Please 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, please 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, please 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? Please 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, please 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, please 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. Please 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, please see your employer.

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

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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? ❒ HMO Blue New England ❒ HMO Select Network ☐ ❒ PPO Blue Care Elect ❒ Other:_____ ☐ ❒ Dental Blue Freedom (High Option) ❒ Dental Blue Value (Low Option) ❒ Dept._____

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? 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 # / Actively Working? Y ❒ / N ❒ | ❒ 65+ ❒ Disabled ❒ ESRD / 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? 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 # / Actively Working? Y ❒ / N ❒ | ❒ 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 ❒ 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're using separate forms for additional dependent children ❒ Total # of dependents: _____

| | | | |
|---|---|---|---|
| ☐ | Start Date | End Date | |
| ☐ | Start Date | End Date | |
| ☐ | Start Date | End Date | |

## 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.