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 • Voluntary termination • COBRA cancellation (under 18 months or nonpayment)
042	• Over 65, changing to Group Medex® plan. (Requires Medicare A and B) • Over 65, changing to direct-pay Medex plan. (Requires Medicare A and B) • Over 65, changing to Medicare supplement other than Medex plans.
043	• Medicare (age =< 65)

Code #	Reason for Canceling
061	• Left employment • 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

MIIA

Enrollment and Change Form

1. To Be Filled Out by Your Employer

Company Name: Town of Leicester	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 New England Options ☐ HMO Select Network ☐ PPO Blue Care Elect ☐ PPO Blue Options ☐ Other:_____ ☐ Access New England Saver ☐ Blue Choice New England ☐ Dept._____ ☐ Dental Blue ☐ PPO Saver

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: _____

5. Personal Savings Account

	Start Date	End Date	FSA Goal Amount (Please see instructions for limits.): $
☐ HSA: Health Savings Account			
☐ FSA: Health Flexible Spending Account			Health: $
☐ DCFSA: Dependent Care Flexible Spending 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're required to collect the Social Security number for you and any dependent enrolling in your plan.