MASSACHUSETTS

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 read the instructions below carefully.

For members of HMO Blue,® Network Blue,® Blue Choice,® HMO Blue New England,℠ or Blue Choice New England℠: You are required to choose a primary care physician (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. The PCP ID number can also be found by visiting **www.bluecrossma.com** and selecting **Find a Doctor**.

For Access Blue℠ Members: Although you are 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 have Medicare and/or other insurance. Please be sure to circle 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 Section 2 and 3.

Print two copies, one for your records and one for your employer to sign and mail to Blue Cross Blue Shield of Massachusetts. In order to complete your enrollment request, your employer is required to sign the application.

Special Instructions for Student Coverage: If you are seeking coverage for a full-time student dependent over age 19, you may need to fill out a Student Certificate form. Check with your employer to see if this coverage is available.

Blue Cross Blue Shield of Massachusetts
P.O. Box 986001
Boston, MA 02298

#100458W (2/11) PDF

Instructions

Section 1 To Be Filed 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 will not be continuing any Blue Cross Blue Shield coverage, carefully select one of the following and indicate the three-digit code on the form.

Code #	Situation
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 #	Situation
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 Medical or Dental Group # transferring to.

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 person 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 Tell Us About Yourself (Member 1)

Please fill in all information that applies to you.

PCP ID# - If your health plan requires you to choose a primary care physician (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, please call our Physician Selection Service at **1-800-821-1388**. A representative will be happy to help you select a doctor. PCP ID number can be found at **www.bluecrossma.com**, select **Find a Doctor**.

Other Insurance - Do you have other health insurance or Medicare? Please be sure to circle either **Y** (for *yes*) or **N** (for *no*)) in the correct box. If you have other insurance, please write the name of the other insurance company and its location (city and state).

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 Tell Us About Your Spouse (Member 2)

If you choose a **Family** membership, please fill in this section if you want Member 2 to be covered. (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 has other insurance, please write the name of the other insurance company and its location (city and state).

Section 4 Tell Us About 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. (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. Please 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 Select 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.

HSA - Check this box if you have or are opening a Health Savings Account.

FSA - Health - Check this box if you have or are opening a Health Flexible Spending Account.

FSA - Dep. - Check this box if you have or are opening a Dependent Care Reimbursement Account.

FSA Goal Amounts - Enter the goal amount for the FSA that you are choosing. Check with your employer for any limit amounts or restrictions associated with these types of flexible spending accounts.

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 are transferring from one medical/dental plan to another medical/dental plan, please provide notification that you will be continuing your personal savings account by completing Section 5 of the Enrollment and Change form.

Section 6 Signatures (Employer & Employee)

Employee: Please sign & date the application and return it to your employer. Employer: Please sign & date the application and return to Blue Cross Blue Shield of Massachusetts.

NETWORK BLUE SELECT PLAN - LIMITED DOCTOR AND HOSPITAL NETWORK

Please Read the Instructions Before Filling Out This Form.

Please **PRINT CLEARLY** using blue or black ink to avoid coverage delay or type in information

MASSACHUSETTS

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

Enrollment and Change Form.

Please mail to: P.O. Box 986001
Boston, MA 02298 or fax to **1-617-246-7531**

1. To Be Filled Out by Your Employer

Company Name	Current Medical Group #:	Medical Group #, Transferring To
TOWN OF DEDHAM - Retiree	**BENCHMARK SELECT PLAN 00-4069887**	

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
- ❒ CHANGE
- ❒ TRANSFER
- ❒ CANCEL

(If canceling, please see instructions for three digit termination code.) ☐ ☐ ☐

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. Tell Us About Yourself (Member 1)

What products are you selecting?
- ❒ HMO Blue
- ☒ Network Blue
- ❒ Blue Choice
- ❒ Saver Blue
- ❒ Dental Blue
- ❒ Access Blue
- ❒ PPO
- ❒ HMO Blue New England
- ❒ Blue Choice New England
- ❒ Group Medex or Managed Blue for Seniors
- ❒ Blue Medicare Rx (Part D)

Kind of Membership (Medical)
- ❒ Individual
- ☒ Family

Kind of Membership (Dental)
- ❒ Individual
- ❒ Family **N/A**

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

Street Address / P.O. Box #:	Apt. #:	City / Town	State	Zip Code

Social Security #:	Telephone #: (area code) ( )	Other Insurance?[1] Y ❒ / N ❒	Other Insurance Company Name	City / State

PCP ID #: (see instructions)	Name of PCP	City / State	Is this your current PCP? Mark X, if yes.
			☐

Are you covered by Medicare? 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	Actively Working? Y ❒ / N ❒ If Retired, Date:

3. Tell Us About (Member 2)

Please Check One: ❒ Spouse ❒ Domestic Partner ❒ Divorced Spouse (court ordered)

Member 2's First Name	M.I.	Last Name	Sex	Date of Birth

Street Address / P.O. Box #:	Apt. #:	City / Town	State	Zip Code

Social Security #:	Telephone #: (area code) ( )	Other Insurance?[1] Y ❒ / N ❒	Other Insurance Company Name	City / State

PCP ID #: (see instructions)	Name of PCP	City / State	Is this your current PCP? Mark X, if yes.
			☐

Is Member 2 covered by Medicare?[1] 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	Actively Working? Y ❒ / N ❒ If Retired, Date:

1. *If you have not indicated Yes or No regarding your Medicare or other insurance status, you may receive a follow-up questionnaire.*

4. Tell Us About Your Eligible Dependents (Member 3, 4, and 5)

Dependent's First Name 3.)	M.I.	Last Name	Sex	Full-time student and aged 19 or older ❒ Disabled and aged 26 or older ❒

Social Security #:	Date of Birth	PCP ID #: (see instructions)	Name of PCP	Is this your current PCP? Mark X, if yes.
				☐

Dependent's First Name 4.)	M.I.	Last Name	Sex	Full-time student and aged 19 or older ❒ Disabled and aged 26 or older ❒

Social Security #:	Date of Birth	PCP ID #: (see instructions)	Name of PCP	Is this your current PCP? Mark X, if yes.
				☐

Dependent's First Name 5.)	M.I.	Last Name	Sex	Full-time student and aged 19 or older ❒ Disabled and aged 26 or older ❒

Social Security #:	Date of Birth	PCP ID #: (see instructions)	Name of PCP	Is this your current PCP? Mark X, if yes.
				☐

Please check if you are using separate forms for additional dependent children ❒ Total # of Dependents: _____

5. Select Personal Savings Account

☐ HSA	Start Date:	End Date:	FSA GOAL AMOUNTS: (Please see instructions for maximum limits.)
☐ FSA – Health	Start Date:	End Date:	Health $:
☐ FSA – Dep.	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 _____