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

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 # 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
❒ TRANSFER 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. Yourself (Member 1)

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

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?[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 # / 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?[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 # / 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 are using separate forms for additional dependent children ❒ Total # of dependents: _____

5. Personal Savings Account

	Start Date	End Date	
☐ **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.

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 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 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 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 **bluecrossma.com**, 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, please 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, please 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. 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 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 are 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 Shieldof Massachusetts.

Please mail to:

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

* Under the Affordable Care Act, we are required to collect the Social Security number for you and any dependent enrolling in your plan.

2020 Enrollment Form

Official Use Only: Date Stamp

Blue MedicareRx℠ (PDP) Medicare Prescription Drug Plan

Return completed applications to your Employer
Please refer to the Blue MedicareRx (PDP) Evidence of Coverage for a complete listing of all plan benefits, conditions, limitations, and exclusions of coverage.

Please contact Blue MedicareRx (PDP) if you need information in another format (Large Print)

STEP 1: Please provide information about you. (Please print clearly.)

Group Employer Name		Requested Effective Date of Coverage
Last Name	First Name	MI
Permanent residence street address (P.O. Box is not allowed)		
City	State	ZIP Code
Date of Birth ____ / ____ / ____	☐ Male ☐ Female	Home phone number ( )
Mailing address (only if different from your permanent residence address)		
Street/P.O. Box	City	State / ZIP Code
Retirement date of retiree (month/date/year): ____ / ____ / ____		

STEP 2: Please provide your Medicare Insurance information.

Please take out your Medicare Card to complete this section.
- Please fill in the blanks at the right so they match your red, white and blue Medicare card.

– or –

- Attach a copy of your Medicare card or your letter from the Social Security Administration or Railroad Retirement Board.

You must have Medicare Part A or Part B (or both) to join a Medicare prescription drug plan.

Name

Medicare Number

☐ Male ☐ Female

Is Entitled To
HOSPITAL (Part A)
MEDICAL (Part B)

Effective Date
____ / ____ / ____
____ / ____ / ____

STEP 3: Please read this important information.

You may only enroll in this plan if you are a retiree or the spouse/dependent of a retiree who qualifies for this Blue MedicareRx (PDP) plan based upon prior employment with the employer or union offering this plan. This plan is not available to individuals who work enough hours to qualify to enroll in the employer health plans offered to active employees by the employer or union offering this plan.

If you are a member of a Medicare Advantage Plan (like an HMO or PPO), you may already have prescription drug coverage as part of your Medicare Advantage plan. By joining Blue MedicareRx (PDP), your membership in your Medicare Advantage plan may end. This will affect both your doctor and hospital coverage, as well as your prescription drug coverage. Read the information that your Medicare Advantage plan sends you and if you have questions, contact your Medicare Advantage plan.

If you currently have health coverage from another employer or union, joining Blue MedicareRx (PDP) could affect your employer or union health benefits. If you have health coverage from an employer or union, joining Blue MedicareRx (PDP) may change how your current coverage works. Read the communications your employer or union sends you. If you have questions, visit their website, or contact the office listed in their communications. If there is no information on whom to contact, your benefits administrator or the office that answers questions about your coverage can help.

STEP 4: Please provide your Enrollment Period information.

Please read the following statements and check the box(es) that apply to you. We will contact you for additional information.

☐ I am enrolling during my former employer's Open Enrollment Period.	☐ I am new to Medicare. (Initial Enrollment Period)

STEP 5: Application Agreement Important: Read this information before signing in Section 6 on left.

By completing this enrollment application, I agree to the following: Blue MedicareRx (PDP) is a Medicare Part D drug plan and has a contract with the Federal government. I understand that this prescription drug coverage is in addition to my coverage under Medicare; therefore, I will need to keep my Medicare coverage. It is my responsibility to inform Blue MedicareRx (PDP) of any prescription drug coverage that I have or may get in the future. I can only be in one Medicare prescription drug plan at a time. If I am currently in a Medicare prescription drug plan, my enrollment in Blue MedicareRx (PDP) will end my enrollment in my current plan. Enrollment in this plan is generally for the entire year. Once I enroll, I may leave this plan only at certain times of the year and under certain special circumstances by sending a request to my former employer.

Blue MedicareRx (PDP) serves a specific service area. If I move out of the area that Blue MedicareRx (PDP) serves, I need to notify the plan so I can disenroll and find a new plan in my new area. I understand that I must use network pharmacies except in an emergency when I cannot reasonably use Blue MedicareRx (PDP) network pharmacies. Once I am a member of Blue MedicareRx (PDP), I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage document from Blue MedicareRx (PDP) when I get it to know which rules I must follow to get coverage.

I understand that if I leave this plan and do not have or obtain other Medicare prescription drug coverage or creditable coverage (as good as Medicare's), I may have to pay a late enrollment penalty in addition to my premium for Medicare prescription drug coverage in the future.

STEP 6: Signature

I understand that my signature below (or the signature of the person authorized to act on my behalf under the laws of the State where I reside) on this application means that I have read and understand the contents of this application. If signed by an authorized individual (as described above), this signature certifies that 1) this person is authorized under State law to complete this enrollment and 2) documentation of this authority is available upon request by Blue MedicareRx (PDP) or by Medicare.

Authorized signature*	Today's Date _____ / _____ / _____

If you are the authorized representative, you must sign above and provide the following information:

Name	Phone number	Relationship to enrollee	
Street/P.O. Box	City	State	ZIP Code

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.

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1-800-200-4255** (TTY: **711**

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para **1-800-200-4255** (TTY: **711**).

Anthem Insurance Companies, Inc., Blue Cross and Blue Shield of Massachusetts, Inc., Blue Cross & Blue Shield of Rhode Island and Blue Cross and Blue Shield of Vermont are the legal entities which have contracted as a joint enterprise with the Centers for Medicare & Medicaid Services (CMS) and are the risk-bearing entities for Blue MedicareRx (PDP) plans. The joint enterprise is a Medicare approved Part D Sponsor. Enrollment in Blue MedicareRx (PDP) depends on contract renewal.

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