Blue20/20

Application / Change Form

Please print clearly.
Please use a black or blue pen.

Blue 20/20 Group No.

☐ **New Enrollee**
(Please Complete A, C, D and E)

☐ **Change Request**
(For changes, complete Sections A, B and all other applicable sections. Plan changes can only be made at Open Enrollment or due to a qualifying event.)

☐ **Termination Date:** ____________________

A. Employee Information

Name of Employer:		Effective Date:		Dept. / Division:	
Social Security Number:		Date of Birth:	Sex: ☐ Male ☐ Female		
Last Name:		First Name:	MI:	Marital Status: ☐ Single ☐ Married	
Mailing Address:		City:		State:	Zip Code:
Date of Hire:	Home Phone Number:	Work Phone Number:		E-Mail Address:	

B. If Making a Change from Previous Enrollment

Check All That Apply:

☐ Name Change
☐ Employee SSN Correction
☐ Add/Remove Dependent
☐ Address/Telephone Number Change
☐ Date of Birth Correction
☐ Late Enrollee
☐ Other:

Add Dependent(s):

	Date of Occurrence
☐ Marriage	________
☐ Domestic Partner	________
☐ Newborn (up to age 1)	________
☐ Adoption	________
☐ Court Order	________
☐ Loss of Coverage	________
☐ Other	________

Date

☐ **Remove Dependent(s)** ________

Reason: ____________________

Reinstate Coverage:

Date: ____________________

Reason: ____________________

Terminate Coverage:

Date: ____________________

Reason: ____________________

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C. Coverage Selection

Options Selected: ☐ Employee ☐ Employee plus Spouse or Domestic Partner
☐ Employee plus Child ☐ Family

D. Family Information—Complete for anyone taking or dropping Blue 20/20 Coverage*

	Name (First, MI, Last Name)	Social Security Number	Date of Birth mm/dd/yyyy	Relationship	Sex
☐ Add / ☐ Delete					☐ F ☐ M
☐ Add / ☐ Delete					☐ F ☐ M
☐ Add / ☐ Delete					☐ F ☐ M
☐ Add / ☐ Delete					☐ F ☐ M
☐ Add / ☐ Delete					☐ F ☐ M
☐ Add / ☐ Delete					☐ F ☐ M
☐ Add / ☐ Delete					☐ F ☐ M

* Application does not guarantee enrollment.

Eligibility Notes:

1. Employees are eligible for coverage if they meet the definition of an eligible employee as defined by their employer and Blue Cross Blue Shield of Massachusetts.
2. Domestic Partners are eligible for coverage if they meet the definition of a Domestic Partner and if allowed by the employer.
3. Dependent Children are eligible for coverage up to age 26.

E. Statement of Understanding

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 vision plan.

______________________________ Signature of Employee

______________________________ Date

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