

Please Read the Instructions Before Filling Out This Form.



This form is for employees on active (HMO or PPO) plans only. Any Medex or Medicare-related transactions should use the Retiree application.



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

MASSACHUSETTS

Enrollment and Change Form

1. Employer Section

Account Name: City of Peabody		Current Medical Group #:		Medical Group # Transferring To:	
Department: School Active	Requested Effective Date:	Date of Hire:	Current Dental Group #:	Dental Group # Transferring To:	
Type of Transaction: <input type="checkbox"/> ADD <input type="checkbox"/> CANCEL <input type="checkbox"/> CHANGE Three digit termination code <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> TRANSFER		Remarks: <input type="checkbox"/> Open Enrollment <input type="checkbox"/> Change to Family <input type="checkbox"/> Loss of Coverage <input type="checkbox"/> New Hire <input type="checkbox"/> Add Spouse <input type="checkbox"/> COBRA <input type="checkbox"/> Add Dependent <input type="checkbox"/> Other: _____			

2. Subscriber (You)

Network Blue Select (HMO)	Blue Care Elect HCCS (PPO)	Dental Blue Low	Dental Blue Retirees	Coverage Type (Medical)	Coverage Type (Dental)
Network Blue NE HCCS (HMO)	Access Blue NE Saver (HMO)	Dental Blue High		<input type="checkbox"/> Individual <input type="checkbox"/> Family	<input type="checkbox"/> Individual <input type="checkbox"/> 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)	PCP ID #	Name of PCP		PCP City	

3. Spouse

First Name	M.I.	Last Name		Sex	Date of Birth
Social Security # (REQUIRED)	PCP ID #	Name of PCP		PCP City	

4. Dependent Children

1.) First Name	M.I.	Last Name		Sex	Date of Birth
Social Security # (REQUIRED)	PCP ID #	Name of PCP		PCP City	
2.) First Name	M.I.	Last Name		Sex	Date of Birth
Social Security # (REQUIRED)	PCP ID #	Name of PCP		PCP City	
3.) First Name	M.I.	Last Name		Sex	Date of Birth
Social Security # (REQUIRED)	PCP ID #	Name of PCP		PCP City	
4.) First Name	M.I.	Last Name		Sex	Date of Birth
Social Security # (REQUIRED)	PCP ID #	Name of PCP		PCP City	
5.) First Name	M.I.	Last Name		Sex	Date of Birth
Social Security # (REQUIRED)	PCP ID #	Name of PCP		PCP City	
6.) First Name	M.I.	Last Name		Sex	Date of Birth
Social Security # (REQUIRED)	PCP ID #	Name of PCP		PCP City	

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 _____