MASSACHUSETTS

Please Read The Instructions Before Filling Out This Form.

Massachusetts MIIA Interlocal Insurance Association

Enrollment and Change Form

Please mail to: M.I.I.A., 1 Winthrop Square, Boston, MA 02110

1. To Be Filled Out by Your Employer

Company Name	Current Medical Group	Medical Group Transferring To

Current BCBS ID Number, if any	Requested Effective Date (MM DD YYYY)	Date of Hire (MM DD YYYY)	Initial Eligibility Date (MM DD YYYY)	Current Dental Group	Dental Group Transferring To

Type of Transaction: Add [X] Change [X] Cancel (Please fill in termination code, see instructions)

Remarks: (i.e., qualifying event for a new add, change to family, or further instruction)

2. Tell Us About Yourself (Member 1)

What product are you selecting? HMO Blue [X] Network Blue [X] Blue Choice [X] Dental Blue [X] HMO Blue New England [X] Blue Choice New England [X] PPO [X] Other (write name of Plan) [X] ______

Kind of Membership (Medical) Individual [X] Family [X]

Kind of Membership (Dental) Individual [X] Family [X]

Your First Name	M.I.	Last Name	Sex	Date of Birth (MM DD YYYY)

Street Address / P.O. Box No.	Apt. No.	City/Town	State	Zip Code

Social Security No.	Home Telephone No. (include area code)	PCP Number	Is this your current PCP? Mark X, if yes. [X]

Name of PCP	City/Town	Other Insurance? Y / N	Other Insurance Company Name	City/State

Are you or anyone Listed Below Covered by Medicare? * Y / N	Part A Effective Date (MM DD YYYY)	Part B Effective Date (MM DD YYYY)	Medicare No. ______ [X] 65+ [X] disabled [X] ESRD	Actively Working Y / N Retired Y / N If yes, date:

** If you have not indicated yes or no regarding your Medicare status, you may receive a follow-up questionnaire.*

3. Tell Us About Your Spouse (Member 2)

Spouse's First Name	M.I.	Spouse's Last Name	Sex	Date of Birth (MM DD YYYY)

Social Security No.	Home Telephone No. (include area code)	PCP Number	Is this your current PCP? Mark X, if yes. [X]

Name of PCP	City/State	Other Insurance? Y / N	Other Insurance Company Name	City/State

Part A Effective Date (MM DD YYYY)	Part B Effective Date (MM DD YYYY)	Medicare No. ______ [X] 65+ [X] disabled [X] ESRD	Actively Working Y / N Retired Y / N If yes, date:

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

Child's First Name	M.I.	Child's Last Name	Sex	Full-time student? Age 19 or over Y / N

Date of Birth (MM DD YYYY)	Social Security No.	PCP Number	Name of PCP	Is this your current PCP? Mark X, if yes. [X]

Child's First Name	M.I.	Child's Last Name	Sex	Full-time student? Age 19 or over Y / N

Date of Birth (MM DD YYYY)	Social Security No.	PCP Number	Name of PCP	Is this your current PCP? Mark X, if yes. [X]

Child's First Name	M.I.	Child's Last Name	Sex	Full-time student? Age 19 or over Y / N

Date of Birth (MM DD YYYY)	Social Security No.	PCP Number	Name of PCP	Is this your current PCP? Mark X, if yes. [X]

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 authorize Blue Cross and Blue Shield to obtain medical records or information from the Social Security Administration, Medicare contractors, other health care programs, insurers or any government agency to verify eligibility, claims payment information or properly coordinate benefits.

Employee's Signature ______ Date ______ Employer's Signature ______ Date ______

Blue Cross Blue Shield of Massachusetts is an Independent Licensee of the Blue Cross and Blue Shield Association

Massachusetts
MIIA
Interlocal Insurance Association

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Thank you for choosing a Blue Cross and 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 and follow the instructions below and on the back of this page.

Important: Are You Covered by Medicare?

We need to know whether you or your dependents are also covered by Medicare.

There is a question: **Are You or Any Family Member Listed Below Covered By Medicare?** Please be sure to write either **Y** (for "yes") or **N** (for "no") in the correct box to let us know whether any member has Medicare, too. We need to know who has Medicare in order to process your claims without delay.

Special Instructions for Student Coverage

If you are requesting coverage for a full-time student dependent over age 19, you must also fill out a Student Certification form. (Check with your employer to see if this coverage is available.)

Special Instructions for HMO Blue, Network Blue, Blue Choice®, HMO Blue New England, or Blue Choice New England.

If you're joining one of these HMO or point-of-service (POS) plans, you'll need to choose a primary care physician when you enroll. Please read the **PCP No.** instructions in Section 2 on the back of this page.

Employee keeps pink copy. Employer keeps yellow copy.

Send white copy to:

M.I.I.A.
1 Winthrop Square
Boston, MA 02110

Instructions

Section 1 — To Be Filled Out By Your Employer

Your employer will fill out this section.

Subscriber Termination Codes. If the subscriber will not be continuing any BCBS coverage, carefully select one of the following and indicate the three-digit code on the form.

1 = Left Employment. 061
2 = Deceased.(Exact Date) 070
3 = Moved from Service area. 071
4 = COBRA end. 061
5 = Still employed, but changing to a non-BCBS plan. 041
6 = Over 65, changing to Group Medex plan. (Requires Medicare A and B) 042
7 = Over 65, change to Direct-pay Medex plan. (Requires Medicare A and B) 042
8 = Over 65, changing to Medicare supplement other than Medex plans. 042

Note: If your subscribers are adding or dropping one benefit only (medical/dental), please indicate "add medical . . . cancel medical . . .," etc. in 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.

Qualifying event for add to coverage:

1. Company open enrollment.
2. Date of hire.
3. End of company probationary period, if any, otherwise date of hire.
4. Lost coverage through spouse or parent (include documentation from prior company).

. . . For change to family:

1. Company open enrollment
2. Date of marriage, within approved retroactive period.

Section 2 — Tell Us About Yourself (Member 1)

Please fill in all information that applies to you.

PCP No. — If your health plan requires you to choose a primary care physician (PCP), please fill in this section. Write the PCP number (***not*** the telephone number) of the doctor you have chosen to coordinate your health care. You'll find the doctor's PCP 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.

Other Insurance — Do you have other insurance? Please be sure to write either **Y** (for "yes") or **N** (for "no") in the correct box. If yes, 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 shaded areas in Section 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 (spouse) and/or Section 4 (dependents).

Section 3 — Tell Us About Your Spouse (Member 2)

If you choose a **Family** membership, please fill in this section if you want your spouse to be covered.
(A spouse cannot be covered under an **Individual** membership.)

Section 4 — Tell Us About Your 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. (Dependents cannot be covered under an **Individual** membership.) If you have more than three dependents to be covered, please use a second Enrollment Form.

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