

Please Read the Instructions Before Filling Out This Form.



Enrollment and Change Form

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

MASSACHUSETTS

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 MOUNT HOLYOKE COLLEGE	Requested Effective Date	Date of Hire
Remarks: (i.e., qualifying event for a new add, change to family or other instruction)		

2. Yourself (Member 1)

What products? <input type="checkbox"/> Dental Blue with Ortho <input type="checkbox"/> Dental Blue	<input type="checkbox"/> HMO Blue <input type="checkbox"/> HMO Blue New England (Value) <input type="checkbox"/> PPO 90	Membership Type (Medical) <input type="checkbox"/> Individual <input type="checkbox"/> EE & Spouse <input type="checkbox"/> EE & Child(ren) <input type="checkbox"/> Family	Membership Type (Dental) <input type="checkbox"/> Individual <input type="checkbox"/> Family		
Your 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 <input type="checkbox"/> / N <input type="checkbox"/>	Other Insurance Company Name	City / State		
PCP ID # (see instructions)	Name of PCP	City / State	Is this your current PCP? Y <input type="checkbox"/> / N <input type="checkbox"/>		
Are you covered by Medicare? ² Y <input type="checkbox"/> / N <input type="checkbox"/>	Part A Effective Date MM DD YYYY	Part B Effective Date MM DD YYYY	Part D Effective Date MM DD YYYY	Medicare #	<input type="checkbox"/> 65+ <input type="checkbox"/> Disabled <input type="checkbox"/> ESRD
				Actively Working? Y <input type="checkbox"/> / N <input type="checkbox"/>	If Retired, Date

3. Member 2

Please Check One: <input type="checkbox"/> Spouse <input type="checkbox"/> Domestic Partner <input type="checkbox"/> Divorced Spouse (court ordered)		Plan Type: <input type="checkbox"/> Medical <input type="checkbox"/> Dental			
First Name	M.I.	Last Name	Sex	Date of Birth	
Social Security # (REQUIRED) ¹	Phone ()	Other Insurance? ¹ Y <input type="checkbox"/> / N <input type="checkbox"/>	Other Insurance Company Name	City / State	
PCP ID # (see instructions)	Name of PCP	City / State	Is this your current PCP? Y <input type="checkbox"/> / N <input type="checkbox"/>		
Are you covered by Medicare? ² Y <input type="checkbox"/> / N <input type="checkbox"/>	Part A Effective Date MM DD YYYY	Part B Effective Date MM DD YYYY	Part D Effective Date MM DD YYYY	Medicare #	<input type="checkbox"/> 65+ <input type="checkbox"/> Disabled <input type="checkbox"/> ESRD
				Actively Working? Y <input type="checkbox"/> / N <input type="checkbox"/>	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 <input type="checkbox"/> / N <input type="checkbox"/>	Full-time student and aged 19 or older <input type="checkbox"/> Disabled and aged 26 or older <input type="checkbox"/>	Plan Type: <input type="checkbox"/> Medical <input type="checkbox"/> 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 <input type="checkbox"/> / N <input type="checkbox"/>	Full-time student and aged 19 or older <input type="checkbox"/> Disabled and aged 26 or older <input type="checkbox"/>	Plan Type: <input type="checkbox"/> Medical <input type="checkbox"/> 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 <input type="checkbox"/> / N <input type="checkbox"/>	Full-time student and aged 19 or older <input type="checkbox"/> Disabled and aged 26 or older <input type="checkbox"/>	Plan Type: <input type="checkbox"/> Medical <input type="checkbox"/> Dental			
Please check if you are using separate forms for additional dependent children <input type="checkbox"/> Total # of dependents: _____					

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 _____

- REQUIRED: Under the Affordable Care Act, we are required to collect the Social Security number for you and any dependent enrolling in your plan.
- If you have not indicated Y or N regarding your Medicare or other insurance status, you may receive a follow-up questionnaire.

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

If you are enrolling your spouse, you must provide a copy of your marriage certificate.