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

1. To Be Filled Out by Your Employer

Account Name: **Mayflower Municipal Health Group**	Entity Name: Town of Bridgewater	Group Number:
Current BCBS ID #, If any	Requested Effective Date: MM DD YYYY	Date of Hire: MM DD YYYY

Type of Transaction
❒ ADD ❒ CANCEL
❒ CHANGE Three-digit
❒ TRANSFER termination code ☐☐☐

Remarks: (e.g., 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?
❒ Traditional HMO Blue Legacy
❒ Rate Saver HMO Blue NE
❒ Benchmark HMO Blue NE Ded w HCCS
❒ Access Blue NE Saver HDHP
❒ Traditional PPO Pref Legacy
❒ Rate Saver PPO Value Plus
❒ Benchmark PPO Blue Care Elect Ded w HCCS
❒ Blue Care Elect Saver HDHP
❒ Medex 2
❒ Managed Blue for Seniors

Membership Type (Medical)
❒ 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)**

First Name	M.I.	Last Name	Sex	Date of Birth
Social Security # (REQUIRED)[1]	Phone	Other Insurance?[1] 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 ❒		
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 ❒		
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 ❒		

Please check if you are using separate forms for additional dependent children ❒ Total # of dependents: _____

5. Personal Savings Account

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