# TOWN OF WESTBOROUGH

MASSACHUSETTS

## Blue Cross Blue Shield of Massachusetts - Enrollment and Change Form

### 1. To Be Filled Out by Employer

**Current Med. Grp#:** _____ **Transferring to Med. Grp#:** _____ **Eff. Date:** _____

**Current Dent. Grp#:** _____ **Transferring to Dent. Grp#:** _____ **Eff. Date:** _____

### 2. Yourself (Member 1)

**Date of Hire:** _____ ☐ Add/New ☐ Cancel/Term ☐ Chg to Ind. ☐ Chg to Fam. ☐ Add New Dep.

☐ New Hire ☐ Open Enrollment ☐ Loss of Coverage **Remarks:** _____

**PRODUCTS:** **Medical** ☐ HMO Blue New Eng ☐ Blue Care Elect PPO *(Restricted-Call HR)* ☐ Access Blue HD **Dental** ☐ High ☐ Low

**Medical Coverage** ☐ Single ☐ Family **Dental Coverage** ☐ Single ☐ Family

**Name *(First MI Last):*** _____ **DOB** _____ ☐ Male ☐ Female

**Street Address / P.O. Box #:** _____
*Include Apt. #, City, State & Zip Code*

**Phone (H):** _____ **Phone (C):** _____ **Email:** _____

**Social Sec. #:** _____ **PCP Name & ID #:** _____ ***Current PCP?*** ☐ Yes ☐ No
***(REQUIRED)*** *HMO Members ONLY: myfindadoctor.bluecrossma.com*

### 3. Member 2

**Please Check:** ☐ Spouse ☐ Divorced Spouse *(court ordered)* ☐ Other _____

**Name *(First MI Last):*** _____ **DOB** _____ ☐ Male ☐ Female

**Social Sec. #:** _____ **PCP Name & ID #:** _____ ***Current PCP?*** ☐ Yes ☐ No
***(REQUIRED)*** *HMO Members ONLY: myfindadoctor.bluecrossma.com*

### 4. Your Eligible Dependents (Members 3, 4 and 5)

**Dep 1 Name *(First MI Last):*** _____ **DOB** _____ ☐ Male ☐ Female

**Social Sec. #:** _____ **PCP Name & ID #:** _____ ***Current PCP?*** ☐ Yes ☐ No
***(REQUIRED)*** *HMO Members ONLY: myfindadoctor.bluecrossma.com*

**Dep 2 Name *(First MI Last):*** _____ **DOB** _____ ☐ Male ☐ Female

**Social Sec. #:** _____ **PCP Name & ID #:** _____ ***Current PCP?*** ☐ Yes ☐ No
***(REQUIRED)*** *HMO Members ONLY: myfindadoctor.bluecrossma.com*

**Dep 3 Name *(First MI Last):*** _____ **DOB** _____ ☐ Male ☐ Female

**Social Sec. #:** _____ **PCP Name & ID #:** _____ ***Current PCP?*** ☐ Yes ☐ No
***(REQUIRED)*** *HMO Members ONLY: myfindadoctor.bluecrossma.com*

### 5. OTHER Coverage *(if NONE use N/A)*

**Please Describe "OTHER" Coverage *(Name of Ins. Co., ID #)*** _____

**Medicare *(Effective Date, Medicare #, Parts A or B, Age 65 or Disability)*** _____

### 6. Signature (Employer & Employee)

The information here is complete and true. I understand that Blue Cross & 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 provied by my employer to understand my benefits and any restrictions that apply to my health care plan. I understand that Blue Cross & Blue Shield may obtain personal and medical information about me to carry out its business, and that it may use and disclosed that information in accordance with law. I acknowledge that I may obtain further information about the collection, use and disclosure of my nformation in "our Commitment to Confidentiality," Blue Cross & Blue Shield's notice of privacy practices.

***Employee Sign*** _____ ***Date*** _____ ***Employer Sign*** _____ ***Date*** _____