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

IF ENROLLLING IN DENTAL CIRCLE ONE OPTION

OPTION 1 OPTION 2

Enrollment and Change Form

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	Current Medical Group #:	Medical Group # Transfering To:
LOWER PIONEER VALLEY EDUCATIONAL COLLABORA		

Current BCBS ID #, If any	Requested Effective Date	Date of Hire	Current Dental Group #:	Dental Group # Transferring To
	07/01/2024 MM DD YYYY	MM DD YYYY		

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

Remarks: (i.e., qualifying event for a new add, change to family or other instruction) CHOOSE: OPTION 1 _____ OPTION 2 ___X___

☑ Open Enrollment ☐ Change to Family ☐ Loss of Coverage (HIPAA Continuation of Coverage Letter required)
☐ New Hire ☐ Add Spouse ☐ Other: _____
☐ COBRA ☐ Add Dependent

2. Yourself (Member 1)

What products? ☐ Access Blue ☐ Blue Choice ☐ Blue Choice New England ☐ Blue Medicare Rx (Part D) ☐ Dental Blue ☐ HMO Blue ☐ HMO Blue New England ☐ Managed Blue for Seniors ☐ Medex (Group) ☐ Network Blue ☐ PPO ☐ Saver Blue

Membership Type (Medical) ☐ Individual ☐ Family

Membership Type (Dental) ☐ Individual ☐ Family

First Name	M.I.	Last Name	Sex	Date of Birth
KEVIN		MURDOCK	M	12/18/1966

Street Address/ P.O. Box #	Apt. #	City/ Town	State	Zip Code
934 CAREW STREET		SPRINGFIELD	MA	01104

Home Phone ( )	Cell Phone ( )	Email

Social Security # (REQUIRED)[1]	Other Insurance?[2]	Other Insurance Company Name	Member Identification Number
030-60-9954	Y ☐ / N ☐		

PCP ID # (see instructions)	Name of PCP	City / State	Is this your current PCP?
NOT NEEDED FOR DENTAL	NOT NEEDED FOR DENTAL		Y ☐ / N ☐

Are you covered by Medicare?[2]	Part A Effective Date	Part B Effective Date	Part D Effective Date	Medicare #	
Y ☐ / N ☐	MM DD YYYY	MM DD YYYY	MM DD YYYY		☐ 65+ ☐ Disabled ☐ ESRD
				Actively Working? Y ☐ / N ☐	If Retired, Date

3. Member 2

Please Check One: ☐ Spouse ☐ Domestic Partner ☐ Divorced Spouse (court ordered) Plan Type: ☐ Medical ☐ Dental

First Name	M.I.	Last Name	Sex	Date of Birth

Social Security # (REQUIRED)[1]	Phone ( )	Other Insurance?[1]	Other Insurance Company Name	Member Identification Number
		Y ☐ / N ☐		

PCP ID # (see instructions)	Name of PCP	City / State	Is this your current PCP?
NOT NEEDED FOR DENTAL	NOT NEEDED FOR DENTAL		Y ☐ / N ☐

Are you covered by Medicare?[2]	Part A Effective Date	Part B Effective Date	Part D Effective Date	Medicare #	
Y ☐ / N ☐	MM DD YYYY	MM DD YYYY	MM DD YYYY		☐ 65+ ☐ Disabled ☐ ESRD
				Actively Working? Y ☐ / N ☐	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
		NOT NEEDED FOR DENTAL

Is this your current PCP? Y ☐ / N ☐ Full-time student and aged 19 or older ☐ Disabled and aged 26 or older ☐ Plan Type: ☐ Medical ☐ 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
		NOT NEEDED FOR DENTAL

Is this your current PCP? Y ☐ / N ☐ Full-time student and aged 19 or older ☐ Disabled and aged 26 or older ☐ Plan Type: ☐ Medical ☐ 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
		NOT NEEDED FOR DENTAL

Is this your current PCP? Y ☐ / N ☐ Full-time student and aged 19 or older ☐ Disabled and aged 26 or older ☐ Plan Type: ☐ Medical ☐ Dental

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

5. Personal Savings Account

	Start Date	End Date	FSA Goal Amount (Please see instructions for limits.): $
☐ **HSA: Health Savings Account**			
☐ **FSA: Health Flexible Spending Account**	Start Date	End Date	Health: $
☐ **FSA: Dependent Care Reimbursement Account**	Start Date	End Date	Dependent Care: $

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 _____

1. REQUIRED: Under the Affordable Care Act, we are required to collect the Social Security number for you and any dependent enrolling in your plan.