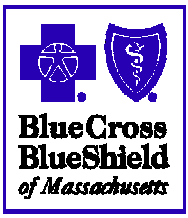

Thank you for choosing a Blue Cross Blue Shield plan.

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.

For members of HMO Blue®, Network Blue, Blue Choice®, HMO Blue New England, or Blue Choice New England:

You are required to choose a primary care physician (PCP) when you enroll. Please choose a PCP from your plan's provider directory, and be sure to read "PCP ID No." in Section 2 on the back of this page and list your PCP choice on your enrollment form.

For Access Blue Members:

Although you are not required to choose a PCP, we recommend you choose one. To choose a PCP, please follow the instructions in Section 2 on the back of this page.

Important: Are You Covered by Medicare or Other insurance?

We need to know if you or any family member listed have Medicare and/or other insurance. This helps us coordinate your benefits accurately. Please be sure to write either Y (for yes) or N (for no) in the correct box. Please follow the instructions in Section 2 on the back of this page.

Special Instructions for Student Coverage

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

Employee keeps pink copy. Employer keeps yellow copy.

Send white copy to:

Blue Cross Blue Shield of Massachusetts
P.O. Box 9145
North Quincy, MA 02171-9145

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. 070 (Exact Date)

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. 042 (Requires Medicare A and B)

7 = Over 65, change to Direct-pay Medex plan. 042 (Requires Medicare A and B)

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," "add dental," "cancel medical," or "cancel dental" in the "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 ID No. — If your health plan requires you to choose a primary care physician (PCP), please fill in this section. Write the PCP ID number (***not*** the telephone number) of the doctor you have chosen to coordinate your health care. You'll find the doctor's PCP ID 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 or Medicare? Please be sure to write either **Y** (for "yes") or **N** (for "no") in the correct box. If you have other insurance, 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 Sections 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.

BlueCross BlueShield of Massachusetts

An Independent Licensee of the Blue Cross and Blue Shield Association

Please Read The Instructions Before Filling Out This Form.

Enrollment and Change Form

Please mail to: BCBS, P.O. Box 9145, North Quincy, MA 02171-9145

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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 (Please fill in termination code, see instructions)

Add ☐ Change ☐ Cancel ☐

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 ☐ Network Blue ☐ Blue Choice ☐ Dental Blue ☐ HMO Blue New England ☐ Blue Choice New England ☐ PPO ☐ Other (write name of Plan) ☐ ____________

Kind of Membership (Medical) Individual ☐ Family ☐

Kind of Membership (Dental) Individual ☐ Family ☐

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)	Other Insurance?* Y / N	Other Insurance Company Name	City/State

Name of PCP	City/State	PCP ID Number	Is this your current PCP? Mark X, if yes. ☐

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. ____ ☐ 65+ ☐ disabled ☐ ESRD	Actively Working Y / N Retired Y / N If yes, date:

**** If you have not indicated yes or no regarding your Medicare or other insurance 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)	Other Insurance? Y / N	Other Insurance Company Name	City/State

Name of PCP	City/State	PCP ID Number	Is this your current PCP? Mark X, if yes. ☐

Part A Effective Date MM DD YYYY	Part B Effective Date MM DD YYYY	Medicare No. ____ ☐ 65+ ☐ disabled ☐ 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 ID Number	Name of PCP	Is this your current PCP? Mark X, if yes. ☐

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 ID Number	Name of PCP	Is this your current PCP? Mark X, if yes. ☐

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 ID Number	Name of PCP	Is this your current PCP? Mark X, if yes. ☐

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 ____________

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same comp as ply 2, but in black ink

Important Information About Your HMO Blue, Network Blue or *Blue Choice®, Coverage*

HMO Blue, Network Blue, Covered Services: Call your primary care physician for all routine and urgent care situations.

Blue Choice Covered Services: To be covered for the highest level of benefits, care must be provided or arranged by your PCP.

Life-Threatening Emergencies: For immediate, life-threatening emergencies, go to the nearest emergency room. Be sure to have someone call your HMO within 48 hours.

Out-of-Area Care: If you are temporarily out of the HMO service area, you will be covered only for the unexpected onset of a serious condition requiring immediate medical or surgical care. Be sure to have someone call your PCP or your HMO within 48 hours.

Our Policy on Collection and Release of Information

We may collect information from your health care providers, other insurance companies, or your employer to help us determine your coverage and administer your benefits. The information we collect will not be released to another party without your permission, except as authorized by law. You have the right to access the information we collect and to request a correction of any information you believe is incorrect. A more detailed description of our information practices is available upon written request.