



Instructions

Section 1 To Be Filled Out by Your Employer

Your employer will fill out this section.

Type of Transaction—Check the box(es) that apply.

Subscriber Cancellation Codes—If the subscriber won't be continuing any Blue Cross Blue Shield coverage, carefully select one of the following and indicate the three-digit code on the form.

Code #	Reason for Canceling
041	<ul style="list-style-type: none"> Changing to other health plan Voluntary termination COBRA cancellation (under 18 months or nonpayment)
042	<ul style="list-style-type: none"> Over 65, changing to Group Medex[®] plan (Requires Medicare A and B) Over 65, changing to direct-pay Medex plan (Requires Medicare A and B) Over 65, changing to Medicare supplement other than Medex plans
043	<ul style="list-style-type: none"> Medicare (age =< 65)

Code #	Reason for Canceling
061	<ul style="list-style-type: none"> Left employment COBRA ending
063	<ul style="list-style-type: none"> Transfer
064	<ul style="list-style-type: none"> Cancellation as of original effective date
070	<ul style="list-style-type: none"> Deceased
071	<ul style="list-style-type: none"> Moved out of state (out of HMO service area)
076	<ul style="list-style-type: none"> Military service

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.

If a subscriber is being moved from an active group to a retiree group (within the same account), this is a transfer and not a termination. Please include the Medical or Dental Group # transferring to.

Cancellation date will be the first day of no coverage.

Qualifying Events—Remarks:

To assist in the enrollment process, please use check boxes or write applicable information in the "Remarks" section of the form.

- **Open Enrollment**—Check this box for open enrollment.
- **New Hire**—Check this box for new hires to the company.
- **COBRA**—Check this box if person is continuing coverage under COBRA.
- **Add Spouse**—Check this box if spouse is being added. Ensure that date of marriage is within approved retroactive period.
- **Add Dependent**—Check this box if adding any dependent.
- **Loss of Coverage**—Check this box if employee lost coverage through spouse or parent. Please include HIPAA Continuation of Coverage Letter from prior company/insurer. If you have questions, contact your account service representative.
- **Other**—Check this box if change to family requires additional explanation. Please write in the reason for change (e.g., court order, adoption, New Dependent Law under HCR, legal guardianship, etc.). Include supporting documentation. If you have questions, contact your account service representative.

Section 2 Yourself (Member 1)

Please fill in all information that applies to you. (REQUIRED)*

Gender—Enter M for male, F for female, or NB for non-binary

PCP ID#—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. PCP ID number can be found at bluecrossma.com, select **Find a Doctor**.

Other Insurance—Do you have other health insurance or Medicare in addition to your Blue Cross Blue Shield plan? Please be sure to circle 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 your member identification number.

To Add or Delete a Member—Are you adding or deleting a member under your existing membership? If yes, please fill in the area in Section 2. Then, give us the details about the members you're adding or deleting in Section 3 and/or Section 4.

Section 3 Member 2

If you choose a **Family** membership, please fill in this section if you want Member 2 to be covered. (REQUIRED)* (**Note:** Member 2 can't be covered under an **Individual** membership.)

Gender—Enter M for male, F for female, or NB for non-binary

Other Insurance—Does your spouse or partner have other health insurance or Medicare? Please be sure to circle either **Y** (for yes) or **N** (for no) in the correct box. If your spouse or partner has other insurance, please write the name of the other insurance company and your member identification number.

Section 4 Your Eligible 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. (REQUIRED)*

(**Note:** Dependents can't be covered under an **Individual** membership.)

Gender—Enter M for male, F for female, or NB for non-binary

If you have more than three dependents to be covered, please use additional Enrollment Forms as needed. Please indicate on the form that additional forms have been used, and write the total number of dependents you want to be enrolled.

Section 5 Signatures (Employer & Employee)

Employee: Please sign and date the application and return it to your employer.

Employer: Please sign and date the application and return to Blue Cross Blue Shield of Massachusetts.

Please mail to:

Blue Cross Blue Shield of Massachusetts
P.O. Box 986001
Boston, MA 02298
or fax to 1-617-246-7531

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

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



Minuteman Nashoba Health Group

Enrollment and Change Form

1. To Be Filled Out by Your Employer

Employer Name: Minuteman Nashoba Health Group. Current Medical Group (See Group Number Sheet). Medical Group # Transferring to. Current Blue Cross Blue Shield ID #, If Any. Requested Effective Date. Date of Hire. Type of Transaction: ADD, CANCEL, CHANGE, TRANSFER. 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, Other.

2. Yourself (Member 1)

What products? Network Blue New England, Network Blue Select, Access Blue New England Saver, Network Blue Select Saver. Membership Type: Individual (Medical), Family. First Name, M.I., Last Name, Gender, Date of Birth. Street Address, P.O. Box #, Apt. #, City/Town, State, ZIP Code. Home Phone, Cell Phone, Email. Social Security # (REQUIRED), Other Insurance? 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? Y/N, Part A Effective Date, Part B Effective Date, Part D Effective Date, Medicare #, 65+, Disabled, ESRD, Actively Working? Y/N.

3. Member 2

Please Check One: Spouse, Divorced Spouse (court ordered). Plan Type: Medical. First Name, M.I., Last Name, Gender, Date of Birth. Social Security # (REQUIRED), Phone, Other Insurance? 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? Y/N, Part A Effective Date, Part B Effective Date, Part D Effective Date, Medicare #, 65+, Disabled, ESRD, Actively Working? Y/N.

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

Dependent's First Name, M.I., Last Name, Gender, Date of Birth. Social Security # (REQUIRED), 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, Plan Type: Medical. (Repeat for Dependents 3, 4, and 5.)

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