

Please Read The Instructions
Before Filling Out This Form.

Please PRINT CLEARLY using blue or black ink
to avoid coverage delay or type in information.



MASSACHUSETTS

Blue Cross Blue Shield of Massachusetts is an
Independent Licensee of the Blue Cross and Blue Shield Association

Enrollment and Change Form

Please mail to: Amherst College, Office of Human
Resources, PO Box 5000, Amherst, MA 01002
or fax to (413)-542-2687

1. To Be Filled Out by Your Employer											
Company Name				Current Medical Group #:			Medical Group #, Transferring To				
Current BCBS ID #, If any		Requested Effective Date		Date of Hire		Current Dental Group #:		Dental Group #, Transferring To			
		MM DD YYYY		MM DD YYYY							
Type of Transaction	Remarks: (i.e., qualifying event for a new add, change to family or other instruction)										
<input type="checkbox"/> ADD <input type="checkbox"/> CHANGE <input type="checkbox"/> TRANSFER <input type="checkbox"/> CANCEL	<input type="checkbox"/> Open Enrollment <input type="checkbox"/> New Hire <input type="checkbox"/> COBRA			<input type="checkbox"/> Change to Family <input type="checkbox"/> Add Spouse <input type="checkbox"/> Add Dependent			<input type="checkbox"/> Loss of Coverage (HIPAA Continuation of Coverage Letter Required) <input type="checkbox"/> Other _____				
2. Tell Us About Yourself (Member 1)											
What Products are you selecting?	<input type="checkbox"/> HMO Blue <input type="checkbox"/> Blue Choice <input type="checkbox"/> HMO Blue Deductible Plan		<input type="checkbox"/> Blue Care PPO (out-of-state residents only)			<input type="checkbox"/> Dental Blue <input type="checkbox"/> Dental Blue (with Ortho)		Kind of Membership (Medical) <input type="checkbox"/> Individual <input type="checkbox"/> Family		Kind of Membership (Dental) <input type="checkbox"/> Individual <input type="checkbox"/> Family	
Your First Name			M.I.	Last Name			Sex		Date of Birth		
Street Address / P.O. Box #:			Apt. #:	City / Town			State		Zip Code		
Social Security #:		Telephone #: (area code)		Other Insurance? *		Other Insurance Company Name		City / State			
		()		Y <input type="checkbox"/> / N <input type="checkbox"/>							
PCP ID #:		Name of PCP			City/State			Is this your current PCP? Mark X, if yes. <input type="checkbox"/>			
Are you Covered by Medicare? *	Part A Effective Date		Part B Effective Date		Part D Effective Date		Medicare #:		Actively Working		
Y <input type="checkbox"/> / N <input type="checkbox"/>	MM DD YYYY		MM DD YYYY		MM DD YYYY		<input type="checkbox"/> 65+ <input type="checkbox"/> Disabled <input type="checkbox"/> ESRD		Y <input type="checkbox"/> / N <input type="checkbox"/> If Retired, Date:		
3. Tell Us About (Member 2)											
Please check one: <input type="checkbox"/> Spouse <input type="checkbox"/> Domestic Partner <input type="checkbox"/> Divorced Spouse (court ordered)											
Member 2's First Name			M.I.	Last Name			Sex		Date of Birth		
Street Address / P.O. Box #:			Apt. #:	City / Town			State		Zip Code		
Social Security #:		Telephone #: (area code)		Other Insurance? *		Other Insurance Company Name		City / State			
		()		Y <input type="checkbox"/> / N <input type="checkbox"/>							
PCP ID #:		Name of PCP			City/State			Is this your current PCP? Mark X, if yes. <input type="checkbox"/>			
Is Member 2 Covered by Medicare? *	Part A Effective Date		Part B Effective Date		Part D Effective Date		Medicare #:		Actively Working		
Y <input type="checkbox"/> / N <input type="checkbox"/>	MM DD YYYY		MM DD YYYY		MM DD YYYY		<input type="checkbox"/> 65+ <input type="checkbox"/> Disabled <input type="checkbox"/> ESRD		Y <input type="checkbox"/> / N <input type="checkbox"/> If Retired, Date:		
* If you have not indicated Yes or No regarding your Medicare or other insurance status, you may receive a follow-up questionnaire.											
4. Tell Us About Your Dependents (Member 3, 4, and 5)											
Dependent's First Name			M.I.	Last Name			Sex		Full-time student? Age 19 or Over Y <input type="checkbox"/> / N <input type="checkbox"/>		
Social Security #:		Date of Birth		PCP ID #:		Name of PCP		Is this your current PCP? Mark X, if yes. <input type="checkbox"/>			
Dependent's First Name			M.I.	Last Name			Sex		Full-time student? Age 19 or Over Y <input type="checkbox"/> / N <input type="checkbox"/>		
Social Security #:		Date of Birth		PCP ID #:		Name of PCP		Is this your current PCP? Mark X, if yes. <input type="checkbox"/>			
Dependent's First Name			M.I.	Last Name			Sex		Full-time student? Age 19 or Over Y <input type="checkbox"/> / N <input type="checkbox"/>		
Social Security #:		Date of Birth		PCP ID #:		Name of PCP		Is this your current PCP? Mark X, if yes. <input type="checkbox"/>			
Please check if you are using separate forms for additional dependent children. <input type="checkbox"/> Total # of Dependents : _____											
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		