MASSACHUSETTS

CITY OF NEW BEDFORD

Enrollment and Membership Change Form

Tell Us About You	Current BCBS ID number, if any

Last Name | First name | M.I.

Home Address: Number and Street | Apt. #/P.O. Box

City | State: MA | Zip Code

Home Telephone | Work Telephone | Effective Date (MM/DD/YY)

Department Employee Number

Department

Employee #

Date of Hire (MM/DD/YY)

Please Check the boxes that apply:

NEW MEMBERSHIP
- ☐ Annual Reopening
- ☐ New Enrollment
- ☐ COBRA
- ☐ Loss of Insurance

CHANGE MEMBERSHIP
- ☐ Name/Address Change
- ☐ Add Dependent
- ☐ Terminate Dependent
- ☐ Transfer

CANCEL MEMBERSHIP
- ☐ Left Employ
- ☐ Deceased
- ☐ Moved From Service Area
- ☐ COBRA End
- ☐ Voluntary (Other than above)
- ☐ No Longer Eligible

Your Membership Choices

Check Here if you are enrolling in:
- ☐ HMO-Network Blue NE
- ☐ PPO-Blue Care Elect Preferred
- ☐ Medex 2

Kind of Membership ■ Individual ■ Family

Current Group # | If Transferring, New Group #

List ALL Family Members to Be Covered

	Last Name	First Name	M.I.	Sex (Circle One)	Primary Care Physician (PCP) Name and Number (Refer to Provider Directory) - **HMO only** Check ☐ the box if you currently use this physician
Your Name					**PCP Name:**
Date of Birth (MM/DD/YY)	Social Security #			M F	**PCP #** City / State ☐
Spouse's Name	Last Name	First Name	M.I.		**PCP Name:**
Date of Birth (MM/DD/YY)	Social Security #			M F	**PCP #** City / State ☐

Dependent Information - Please Circle Yes (Y) or No (N) If Dependent Is Disabled

	Last Name	First Name	M.I.		
Dependent					**PCP Name:**
Date of Birth (MM/DD/YY)	Social Security #			M F	Y N **PCP #** City / State ☐
Dependent	Last Name	First Name	M.I.		**PCP Name:**
Date of Birth (MM/DD/YY)	Social Security #			M F	Y N **PCP #** City / State ☐
Dependent	Last Name	First Name	M.I.		**PCP Name:**
Date of Birth (MM/DD/YY)	Social Security #			M F	Y N **PCP #** City / State ☐
Dependent	Last Name	First Name	M.I.		**PCP Name:**
Date of Birth (MM/DD/YY)	Social Security #			M F	Y N **PCP #** City / State ☐

Tell Us About Your Other Insurance

Do you or any other member of your family have any other medical or dental coverage? ☐ Yes ☐ No If yes, please fill in the information below.

Name of Other Insurance Company

Name of Subscriber (Policy Holder) | Policy or ID #

Medicare

Do you or any covered family member have Medicare Coverage? ☐ Yes ☐ No

Name | Is this person a Retiree? ☐ Yes ☐ No

Medicare # | Medicare Part A Effective Date (Hospital) | Medicare Part B Effective Date (Medical)

Remarks

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 (MM/DD/YY) | Employer's Signature | Date (MM/DD/YY)