

Please Read The Instructions Before Filling Out This Form.

Enrollment and Change Form

Please mail to: BCBS, P.O. Box 9145, North Quincy, MA 02171-914

1. To Be Filled Out by Your Employer Company Name	yer			Current Medical Group #			Medical Group # Transferring To		
	ate of I				Current Dental G	oup #	Dental G	roup # Transferring To	
Type of Transaction (Please fill in Remarks: (i.e., qualifying	MM event	DD YYYY I for a new add. cl	MM hange to	ob yyyy a family, or further is	nstruction)	tida damak da ke fin kan i miku maki da maka mana i muun puo puo pu		0000000 de la companya de la company	
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2. Tell Us About Yourself (Member 1)									
HMO Network Blue Dental HMO Blue Blue Choice PPO What product Blue Blue Choice Blue New England New England	Other (wi			Individ	lual Family		Incliv	idual Family	
are you selecting?	Plan).			Membership (Medical)		Kind o Memb (Denta	ership	idual Family	
/our First Name	M.I.	Last Name		est de la comprese del la comprese de la comprese del la comprese de la comprese del la comprese de la comprese del la com			Sex Da	te of Birth	
Street Address / P.O. Box No.	ot. No.	City/Town			State	Zip Code		AM DD YYYY	
Social Security No. Home Telephone No. (include area	code)	Other * Oth Insurance? Y / N	er Insura	nce Company Name	Annance and the contraction of t	Ci	ity/State	2000 til 6 for de menere en	
Name of PCP City/State			PCF	ID Number	errenanten erregigt op de dy't de de geleg til de		s this your o Nark X, if yes	urrent PCP?	
Are you or anyone Part A Effective Date Part A Effective Date Part A Effective Date Part A Effective Date	art B Et	fective Date	Med	licare No. 65+ X disabled	F. T	Actively Work Retired Y / N		If yes, date:	
* If you have not indicated yes or no regarding your Medicare of	r othe	r insurance statu	ıs, you	may receive a folio	ow-up question	naire.		Professional designations are not considerate remains an extensional consideration in the relationship of any programmer property and a professional consideration and the resident and the resid	
3. Tell Us About Your Spouse (Member 2)									
Spouse's First Name	M.I.	Spouse's Last Na	ame			S		te of Birth	
Social Security No. Home Telephone No. (include area	code)	Other Other Insurance?	er Insura	nce Company Name	and the second s	Ci	ity/State	MM DD YYYY	
Name of PCP City/State			PGF	ID Number			s this your or Mark X, if yes		
Part A Effective Date Part B Effective Date Mo	edicare	e No.		Actively W	orking Y / N	O Carteria come con con con conservado de conservado de conservado de conservado de conservado de conservado d			
MM DD YYYY MM DD YYYY	65-	disabled	<u>1 [X</u>	ESRD Retired Y	/ N	If yes, da	ite:	Bert Willer in the state of control of the state of the control of the state of the	
4. Tell Us About Your Dependents (Members 3,	4_a	nd 5)							
Child's First Name	ecoolisus consusses	Child's Last Nam	ne				Sex	Full-time student? Age 19 or over Y / N	
Date of Birth Social Security No.	PCF	ID Number	merile helveled misselvi i Mali komendra i nek mene		Name of PCP			Is this your current PCP? Mark X, if yes.	
Child's First Name	M.I.	Child's Last Nam	ie		til hande det skale helde emmenseren van des verenteren van verenteren verenteren van verenteren van verenteren verent		Sex	Full-time student? Age 19 or over Y / N	
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Child's First Name	M.I.	Child's Last Nam	10		n de la companya del la companya de		Sex	Full-time student? Age 19 or over Y / N	
Date of Birth Social Security No. MM DD YYYY	PCF	ID Number			Name of PCP		ti en	Is this your current PCP? X Mark X, if yes.	
The information here is complete and true. I unde	ersta	nd that Blue	Cross	and Blue Shi	ield will rely	on this i	nformat	ion 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.