



MASSACHUSETTS

Blue 20/20

**New Enrollee**

(Please Complete A, C, D and E)

**Change Request**

(For changes, complete Sections A, B and all other applicable sections.  
Plan changes can only be made at Open Enrollment or due to a  
qualifying event.)

**Termination Date:** \_\_\_\_\_

## Application / Change Form

Please print clearly.  
Please use a black or blue pen.

Blue 20/20 Group No. \_\_\_\_\_

### A. Employee Information

Name of Employer:		Effective Date:		Dept. / Division:	
Social Security Number:		Date of Birth:		Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	
Last Name:		First Name:		MI:	Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married
Mailing Address:			City:		State: _____ Zip Code: _____
Date of Hire:	Home Phone Number:		Work Phone Number:		E-Mail Address: _____

### B. If Making a Change from Previous Enrollment

**Check All That Apply:**

- Name Change
- Employee SSN Correction
- Add/Remove Dependent
- Address/Telephone Number Change
- Date of Birth Correction
- Late Enrollee
- Other: \_\_\_\_\_

**Add Dependent(s):**

	<b>Date of Occurrence</b>
<input type="checkbox"/> Marriage	_____
<input type="checkbox"/> Domestic Partner	_____
<input type="checkbox"/> Newborn (up to age 1)	_____
<input type="checkbox"/> Adoption	_____
<input type="checkbox"/> Court Order	_____
<input type="checkbox"/> Loss of Coverage	_____
<input type="checkbox"/> Other	_____

**Reinstate Coverage:**

Date: \_\_\_\_\_

Reason: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Terminate Coverage:**

Date: \_\_\_\_\_

Reason: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Remove Dependent(s):**

Reason: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**C. Coverage Selection**

**Options Selected:**  Employee  Employee plus Spouse or Domestic Partner  
 Employee plus Child  Family

**D. Family Information—Complete for anyone taking or dropping Blue 20/20 Coverage\***

	Name (First, MI, Last Name)	Social Security Number	Date of Birth mm/dd/yyyy	Relationship	Sex
<input type="checkbox"/> Add / <input type="checkbox"/> Delete					<input type="checkbox"/> F <input type="checkbox"/> M
<input type="checkbox"/> Add / <input type="checkbox"/> Delete					<input type="checkbox"/> F <input type="checkbox"/> M
<input type="checkbox"/> Add / <input type="checkbox"/> Delete					<input type="checkbox"/> F <input type="checkbox"/> M
<input type="checkbox"/> Add / <input type="checkbox"/> Delete					<input type="checkbox"/> F <input type="checkbox"/> M
<input type="checkbox"/> Add / <input type="checkbox"/> Delete					<input type="checkbox"/> F <input type="checkbox"/> M
<input type="checkbox"/> Add / <input type="checkbox"/> Delete					<input type="checkbox"/> F <input type="checkbox"/> M
<input type="checkbox"/> Add / <input type="checkbox"/> Delete					<input type="checkbox"/> F <input type="checkbox"/> M

\* Application does not guarantee enrollment.

**Eligibility Notes:**

1. Employees are eligible for coverage if they meet the definition of an eligible employee as defined by their employer and Blue Cross Blue Shield of Massachusetts.
2. Domestic Partners are eligible for coverage if they meet the definition of a Domestic Partner and if allowed by the employer.
3. Dependent Children are eligible for coverage up to age 26.

**E. Statement of Understanding**

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 vision plan.

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Signature of Employee

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Date

**Visit us at [www.blue2020ma.com](http://www.blue2020ma.com)**

## **Nondiscrimination Notice & Translation Resources**

Blue Cross Blue Shield of Massachusetts complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex, sexual orientation, or gender identity.

**ATTENTION:** If you don't speak English, language assistance services, free of charge, are available to you. Call Member Services at the number on your ID Card (TTY: 711).

**ATENCIÓN:** Si habla español, tiene a su disposición servicios gratuitos de asistencia con el idioma. Llame al número de Servicio al Cliente que figura en su tarjeta de identificación (TTY: 711).

**ATENÇÃO:** Se fala português, são-lhe disponibilizados gratuitamente serviços de assistência de idiomas. Telefone para os Serviços aos Membros, através do número no seu cartão ID (TTY: 711).