



MASSACHUSETTS

Blue<sup>20/20</sup>

# Application / Change Form

**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:** \_\_\_\_\_

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:	Email Address:	

## B. If Making a Change from Previous Enrollment

<b>Check All That Apply:</b> <input type="checkbox"/> Name Change <input type="checkbox"/> Employee SSN Correction <input type="checkbox"/> Add/Remove Dependent <input type="checkbox"/> Address/Telephone Number Change <input type="checkbox"/> Date of Birth Correction <input type="checkbox"/> Late Enrollee <input type="checkbox"/> Other: _____	<b>Add Dependent(s):</b> <input type="checkbox"/> Marriage _____ <b>Date of Occurrence</b> <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 _____	<b>Reinstate Coverage:</b> Date: _____ Reason: _____
	<input type="checkbox"/> <b>Remove Dependent(s)</b> _____ Date: _____ Reason: _____	<b>Terminate Coverage:</b> Date: _____ Reason: _____

### C. Coverage Selection

**Options Selected:**  Employee  Employee plus Spouse or Domestic Partner  
 Employee plus One or More Children  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"/> M <input type="checkbox"/> F
<input type="checkbox"/> Add / <input type="checkbox"/> Delete					<input type="checkbox"/> M <input type="checkbox"/> F
<input type="checkbox"/> Add / <input type="checkbox"/> Delete					<input type="checkbox"/> M <input type="checkbox"/> F
<input type="checkbox"/> Add / <input type="checkbox"/> Delete					<input type="checkbox"/> M <input type="checkbox"/> F
<input type="checkbox"/> Add / <input type="checkbox"/> Delete					<input type="checkbox"/> M <input type="checkbox"/> F
<input type="checkbox"/> Add / <input type="checkbox"/> Delete					<input type="checkbox"/> M <input type="checkbox"/> F
<input type="checkbox"/> Add / <input type="checkbox"/> Delete					<input type="checkbox"/> M <input type="checkbox"/> F

\*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.

\_\_\_\_\_  
Signature of Employee

\_\_\_\_\_  
Date

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

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).