Please Read the Instructions Before Filling Out This Form.

Please TYPE OR PRINT CLEARLY using blue or black ink to avoid coverage delay, or type in information

MASSACHUSETTS

MIIA

Retiree Enrollment and Change Form

1. To Be Filled Out by Your Employer

Municipality Name		
Current BCBS ID #, If Any	Requested Effective Date MM DD YYYY	Current Dental Group #	Dental Group # Transferring to

Type of Transaction	Remarks: (e.g., qualifying event for a new add, change to family, or other instruction)
❒ ADD ❒ CANCEL ❒ TRANSFER	❒ Open Enrollment ❒ Loss of Coverage (HIPAA Continuation of Coverage Letter required) ❒ Other:

2. Yourself

What products?	Membership Type (Dental)
[redacted] ❒ Dental Blue	❒ Individual ❒ Two Person ❒ Family

First Name	M.I.	Last Name	Sex	Date of Birth

Street Address/ P.O. Box #	Apt. #	City/Town	State	ZIP Code

Home Phone ( )	Cell Phone ( )	Email

Social Security # REQUIRED)			
[redacted]			
[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	If Retired, Date

3. Spouse ■ Ex-spouse ■

First Name	M.I.	Last Name	Social Security #	Sex	Date of Birth

4. Signatures (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.

Retiree's Signature	Date	Employer's Signature	Date