



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:					
Last Name:		First Name:		MI:	Marital Status: Single Married				
Mailing Address:	City:			State:	Zip Code:				
Date of Hire: Home Pr		none Number: Work Phone N		lumber:	Email Address:				
B. If Making a Change from Pr	evious Er								
Check All That Apply:		Add Dependent(s):			Reinstate Coverage:				
🗌 Name Change		Date of Occurrence		Date:					
Employee SSN Correction		Marriage			Reason:				
Add/Remove Dependent									
Address/Telephone Number Change		Newborn (up to age 1)			Terminate Coverage: Date: Reason:				
Date of Birth Correction		□ Adoption							
Late Enrollee		Court Order							
Other:		Loss of Coverage							
		Other							
					Reason.				
		Remove Dependent(s)							
		Date:							
		Reason:							

Blue Cross Blue Shield of Massachusetts is an Independent Licensee of the Blue Cross and Blue Shield Association.



C. Coverage Selection										
Options Selected: Employee Des Spouse 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					
Add /					□ M □ F					
Add /					□ M □ F					
Add /					□ м □ F					
Add /					□ M □ F					
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*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

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).

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