

ENROLLING EMPLOYEES IN A HEALTH PLAN

Who Is Eligible for Coverage

This section does not apply to Medicare supplement plans. See Section 7, *When a Member Becomes Eligible for Medicare*.

An employee is eligible for group coverage in an employer's group health plan when there is an identifiable employer/employee relationship, the employee earns income from the employer and claims that income according to state and federal income tax laws, and, **the employee is also:**

- A permanent full-time employee, including an owner, officer, or partner, who is regularly working 30 or more hours each week at the employer's usual place or places of business and for whom the employer pays and reports wages in accordance with state and federal wage requirements; or, if coverage also is offered to part-time employees,
- A permanent part-time employee who is regularly working at least 20 hours (but fewer than 30 hours) each week at the employer's place or places of business and is paid a wage in accordance with federal and state wage requirements.

Questions?
Enrollment Hotline
617-246-9966

If your company has 20 or more employees, the actively working employees and/or their spouses who are age 65 or older must be covered in a non-Medicare supplement group plan if the actively working employee (or his or her spouse) has chosen the group plan as their primary health care coverage. If the employee or spouse has chosen Medicare as the primary health care coverage, you must cancel his or her group coverage.

Additional Eligible Members

The following persons also **may be** considered as eligible group members:

- a disabled employee who is actively working or engaged in a trial work period
- a disabled employee who is not actively working but is considered an employee as part of the employer's clearly defined and consistently administered disability benefit plan
- a person defined under Massachusetts General Laws Chapter 32B, Section 2.(d) as an employee of a governmental unit
- an employee who is covered under a Collective Bargaining Agreement and who is entitled to group coverage under a Health and Welfare Fund
- an owner of at least 50% of the business who may or may not work at the business
- a salesperson receiving commissions in the form of wages but who otherwise meets the definition of a permanent regular full-time (or part-time, if appropriate) employee and for whom eligibility is not based on the attainment of a specific amount of commissions
- prior group members who qualify for continued coverage under federal or state law
- a retired employee who qualifies under the employer's clearly defined and consistently administered retiree benefit plan

Call Your Account Service Representative for More Information on This Subject

ENROLLING EMPLOYEES IN A HEALTH PLAN

Please note:

- Employees selecting a managed care plan must reside in the plan's enrollment area. (See p. 2-6.)
- For more information on active and retired employees age 65 or older, please see **Section 7, *When a Member Becomes Eligible for Medicare.***

This section does not apply to Medicare supplement plans. See **Section 7, *When a Member Becomes Eligible for Medicare.***

When an Employee Is Eligible for Coverage (Employee Qualifying Events)

Initial Enrollment Policy

A member's initial eligibility is a qualifying event for the purposes of determining the member's effective date of coverage with the employer's group health plan.

An eligible employee may enroll in the employer's group plan as an individual or family (if applicable) as of the:

- date of hire or date of completion of the employer's probationary period
- date the employee's permanent regular work hours meet the definition of an eligible employee (20 to 30 hours if part-time and at least 30 hours if full-time)
- date the employee involuntarily lost coverage under a spouse's group plan
- date the employee voluntarily canceled coverage under another health plan due to the total termination of an employer's contribution
- date the employee acquired a new dependent due to marriage, birth, or adoption
- date the employee is required to provide health insurance for a dependent under a Child Support Court Order (child must be enrolled with the employee)

When an eligible member who declined enrollment in the employer's plan due to enrollment in another group plan involuntarily loses that coverage or voluntarily cancels it on the date the employer ceased all contribution, he/she may enroll as of the date the other coverage was canceled. Documentation in the form of a Certificate of Coverage must include the name of the prior employer and insurance carrier, the member's identification number, enrollment and termination dates, and the termination reason and all members covered under the plan. Documentation is not required if the prior coverage was involuntarily lost and was offered or administered by Blue Cross Blue Shield of Massachusetts.

Call Your Account Service Representative for More Information on This Subject

ENROLLING EMPLOYEES IN A HEALTH PLAN

Internal Revenue Code – 125 Trust Plans:

Some employers have established a 125 Trust Plan (cafeteria plan) with the IRS that stipulates when members may be added, removed, or transferred within the employer's group health plan.

The IRS allows the employer to select specific qualifying events from a pre-determined list of events. These include all of the BCBSMA qualifying events as well as one not considered as a qualifying event by us: a significant increase in cost or significant decrease in coverage under the member's current health plan.

If we receive an enrollment request that does not comply with our eligibility policy but does comply with the employer's 125 Trust Plan, the request can be approved with documentation of the employer's qualifying events as filed with the IRS.

Ineligible Persons

The following persons may not be considered as eligible group members and therefore may not enroll in the employer's group health plan:

- a person who works for the employer sporadically or as needed or at will or on a seasonal basis or who does not meet the definition of a permanent regular employee
- a former employee who no longer meets the definition of a permanent regular employee and who does not qualify as eligible as a disabled employee, or as a retired employee, or as a former employee entitled to continued coverage under federal or state law
- corporate directors or trustees who do not meet the definition of a permanent regular employee
- friends, relatives, business associates, or any other persons who do not meet the definition of a permanent regular employee
- contractors, attorneys, consultants, accountants, and other associates who may or may not be paid for periodic services by the employer and/or who do not meet the definition of a permanent regular employee
- any dependent of any of the above person(s)
- any person who is not considered an eligible dependent of an eligible enrolled member
- any otherwise eligible dependent of a member who is eligible but not enrolled
- any person not specified as an eligible member in the plan description and rider(s) that describe the employer's health care plan

Call Your Account Service Representative for More Information on This Subject

ENROLLING EMPLOYEES IN A HEALTH PLAN

Eligibility Conditions After a Member Is Enrolled

This section does not apply to Medicare supplement, managed care, or dental plans.

The First 180 Days Under Some Indemnity Plans

New members generally must be enrolled for 180 consecutive days before they can receive benefits for most covered services under some indemnity plans. During the initial 180 days, coverage will be provided for emergency care services, only.

An account with 51 or more lives may elect to eliminate this limitation period.

Consideration will also be given to reducing or eliminating this initial 180-day limitation period by crediting the time the member was covered under a previous qualifying health plan if such member experiences an interruption of less than 63 days in coverage. To request a waiver of the limitation period, the member must complete a Request for New Member Waiver Form and submit the following documentation:

- A certificate of coverage from the prior insurer or employer or a letter from the prior insurance company stating the exact effective and termination dates of coverage for each family member covered under the prior policy; and
- In the case of prior *non-group* or *student plan* coverage, a benefit plan description.

The member's request will be evaluated under applicable federal and state laws.

Please note: Under Massachusetts General Laws Chapter 32B, municipalities must waive the member's 180-day limitation period on their annual contract renewal date if the member is enrolled in the group prior to that date.

Call Your Account Service Representative for More Information on This Subject

ENROLLING EMPLOYEES IN A HEALTH PLAN

This is an example of how to complete the *Request for New Member Waiver Form*.

Request for New Member Waiver	
Blue Cross and Blue Shield will consider waiving or reducing the period of time that only emergency services are covered if a new member can demonstrate prior continuous health insurance coverage, as well as meet the criteria set forth on the reverse side of this form.	
The information required is listed below. Please complete and return with the required information to your Account Service Representative.	
If all information required is not provided, we cannot process your request! <i>To be completed by your present employer</i>	
Subscriber's name:	<u>Mary Dunphy</u>
Blue Cross and Blue Shield ID number:	<u>XXA012345678</u>
Account name:	<u>Random Company</u>
Group number:	<u>000122456</u>
Subscriber's employment date with your company:	<u>02/02/98</u>
Effective date of subscriber's Blue Cross and Blue Shield coverage with your company:	<u>02/02/98</u>
Authorized signature (present employer):	<u>Ann Smith</u>
<i>For Blue Cross and Blue Shield internal use only</i>	
Date prior employer contacted:	_____
Name of contact person:	_____
Termination reason of prior coverage:	_____
Name of Associate verifying information:	_____
Date information verified:	_____
<i>This portion of the form will be returned to your present employer, advising of the decision on this request for a New Member Waiver.</i>	
Subscriber's name:	_____ ID No.: _____
Request for waiver:	<input type="checkbox"/> Approved <input type="checkbox"/> Denied
Reason:	_____ _____ _____
Effective date of waiver:	_____
Signature:	_____ Date: _____

Request for New Member Waiver Form

Call Your Account Service Representative for More Information on This Subject

ENROLLING EMPLOYEES IN A HEALTH PLAN

How to Enroll Employees

To enroll employees in a health plan, you must submit a completed *Enrollment and Change Form*.

Please note: We encourage you to submit enrollment requests as early as possible. We must receive a notice of a new enrollment to your plan within 30 days of the qualifying event.

If you do not enroll your new employee within 30 days of the requested effective date, the employee is not eligible to enroll until your next open enrollment period.

Do not enclose enrollment requests with your monthly bill. The processing delay could affect employees' coverage.

For Employees Enrolling in HMO Blue, Network Blue, Blue Care®65, and Blue Choice:

- Each member must permanently reside in the designated enrollment area in order to be eligible for plan coverage. Also, except for student dependents, all members must live within the enrollment area at least nine months of the year. The enrollment area comprises the cities and towns described in the plan's service area, as well as specific cities and towns that are contiguous to the service area. Please refer to the plan description for a complete list of the cities and towns in the plan's service area.

Additions: Requests to add members to the employer's plan must be effective as of the member's qualifying event or as of the employer's open enrollment date and must be received by us within 30 days of the requested effective date. All addition requests must be signed and dated by the employer and the employee.

Removals: Requests to remove members from the employer's plan can be effective at any time if we receive the request within 30 days of the requested effective date. All removal requests must be signed and dated by the employer and, except for "left employ" removals, must be signed and dated by the employee.

Transfers: Requests to transfer members from group to group within the employer's plan must be effective as of the member's initial eligibility date for the group transfer or as of the employer's open enrollment date and must be received by us within 30 days of the requested effective date. All transfer requests must be signed and dated by the employer and the employee.

Call Your Account Service Representative for More Information on This Subject

ENROLLING EMPLOYEES IN A HEALTH PLAN

Eligible members may transfer from the employer's managed care plan to another plan of the employer *within 30 days of moving outside of the plan's enrollment area or as of the date the employer no longer offers the managed care plan* as a benefit option.

Eligible members may transfer from another plan of the employer to the employer's managed care plan within 30 days of moving into the plan's enrollment area or as of the date the employer no longer offers the member's current plan as a benefit option.

Reinstatements: Eligible members who were terminated in error by the employer or who were terminated for non-payment of premium may be reinstated as of their termination date when:

- the period of reinstatement is six months or less; and
- the correct termination reason was other than voluntary or transferred to another group plan; and
- the member has not been reinstated more than once within the past 3 years.

Please put your requests in writing to your Account Service Representative.

Exception Enrollment Procedures

Requests for exceptions to our standard eligibility or enrollment policies and procedures are sent to our Member Underwriting Department for review. These requests must include all available documentation and facts to support a decision.

How to Complete the Enrollment and Change Form

All employees who wish to join a health plan – even those who may have been members in the past – must fill out the *Enrollment and Change Form*.

After your employees have completed this form, they must return it to you. Please make sure:

- The application is legible.
- All the appropriate spaces are filled in. (See the following example for an explanation.)
- The application is signed by the employee and you.
- Mail applications to:

Enrollment Department
Blue Cross Blue Shield of Massachusetts
P.O. Box 9145
North Quincy, MA 02171-9145

Questions?
Enrollment Hotline
617-246-9966

See the attachment to the *Enrollment and Change Form* for more details on how to fill out and submit the form.

Call Your Account Service Representative for More Information on This Subject

ENROLLING EMPLOYEES IN A HEALTH PLAN

This is a sample of the *Enrollment and Change Form*.

	Blue Cross BlueShield of Massachusetts <small>An Independent Licensee of the Blue Cross and Blue Shield Association</small>	Please Read The Instructions Before Filling Out This Form.	Enrollment and Change Form <small>Please mail to: BCBS, P.O. Box 9145, North Quincy, MA 02171-9145</small>
1. To Be Filled Out by Your Employer			
Company Name MARK INC.		Current Medical Group 002315	Medical Group Transferring To 0012316
Current BCBS ID Number, if any 012345678	Requested Effective Date 07 01 2003	Date of Hire MM DD YYYY	Initial Eligibility Date MM DD YYYY
Type of Transaction (Please fill in termination code, see instructions) Add <input type="checkbox"/> Change <input type="checkbox"/> Cancel <input checked="" type="checkbox"/> 048		Remarks: (i.e., qualifying event for a new add, change to family, or further instruction) TRANSFER FROM PPO TO HMO	
2. Tell Us About Yourself (Member 1)			
What product are you selecting? <input checked="" type="checkbox"/> HMO Blue <input type="checkbox"/> HMO Silver <input type="checkbox"/> Blue Choice <input type="checkbox"/> HMO Blue New England <input type="checkbox"/> Blue Choice New England <input type="checkbox"/> PPO <input type="checkbox"/> Other (write name of Plan)		Kind of Membership (Medical) <input type="checkbox"/> Individual <input checked="" type="checkbox"/> Family	Kind of Membership (Dental) <input type="checkbox"/> Individual <input checked="" type="checkbox"/> Family
Your First Name ALYSSA		M.I. Last Name M. JONES	Sex Date of Birth F 07 01 1983
Street Address / P.O. Box No. 2 MAIN STREET		Apt. No. City/Town MEDFORD	State Zip Code MA 02155
Social Security No. 012345678	Home Telephone No. (include area code) (781) 335-5623	Other Insurance? Y / N	Other Insurance Company Name City/State
Name of PCP City/State	PCP ID Number	Is this your current PCP? Mark X, if yes. <input checked="" type="checkbox"/>	
Are you or anyone Listed Below Covered by Medicare? * <input type="checkbox"/> Y <input checked="" type="checkbox"/> N	Part A Effective Date MM DD YYYY	Part B Effective Date MM DD YYYY	Medicare No. <input checked="" type="checkbox"/> 65+ <input type="checkbox"/> disabled <input type="checkbox"/> ESRD Retired Y / N <input type="checkbox"/> If yes, date:
* If you have not indicated yes or no regarding your Medicare or other insurance status, you may receive a follow-up questionnaire.			
3. Tell Us About Your Spouse (Member 2)			
Spouse's First Name JULIUS		M.I. Spouse's Last Name JONES	Sex Date of Birth M 06 01 1987
Social Security No. 023456789		Home Telephone No. (include area code) (781) 335-5623	Other Insurance? Y / N
Name of PCP City/State		PCP ID Number	Is this your current PCP? Mark X, if yes. <input checked="" type="checkbox"/>
Part A Effective Date MM DD YYYY	Part B Effective Date MM DD YYYY	Medicare No. <input type="checkbox"/> 65+ <input checked="" type="checkbox"/> disabled <input type="checkbox"/> ESRD Retired Y / N <input type="checkbox"/> If yes, date:	Actively Working Y / N
4. Tell Us About Your Dependents (Members 3, 4, and 5)			
Child's First Name	M.I. Child's Last Name	Sex	Full-time student? Age 19 or over Y / N
Date of Birth MM DD YYYY	Social Security No.	PCP ID Number	Name of PCP
			Is this your current PCP? Mark X, if yes. <input checked="" type="checkbox"/>
Child's First Name	M.I. Child's Last Name	Sex	Full-time student? Age 19 or over Y / N
Date of Birth MM DD YYYY	Social Security No.	PCP ID Number	Name of PCP
			Is this your current PCP? Mark X, if yes. <input checked="" type="checkbox"/>
Child's First Name	M.I. Child's Last Name	Sex	Full-time student? Age 19 or over Y / N
Date of Birth MM DD YYYY	Social Security No.	PCP ID Number	Name of PCP
			Is this your current PCP? Mark X, if yes. <input checked="" type="checkbox"/>
<p>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 authorize Blue Cross and Blue Shield to obtain medical records or information from the Social Security Administration, Medicare contractors, other health care programs, insurers or any government agency to verify eligibility, claims payment information or properly coordinate benefits.</p>			
Employee's Signature <i>Alyssa M. Jones</i>		Employer's Signature <i>John P. Jones</i>	
Date 2/1/03		Date 2/1/03	

Call Your Account Service Representative for More Information on This Subject

ENROLLING EMPLOYEES IN A HEALTH PLAN

The *Enrollment and Change Form* may be used to add, change, or terminate an employee's coverage. For fast and accurate enrollment processing, please use black or blue ink, and write letters and digits as shown:



This is an example and explanation of how to complete the *Enrollment and Change Form*.

The *employer* should fill in section 1:

Fill in your company's name and current medical group numbers.

If the employee is transferring to another health plan administered by Blue Cross and Blue Shield, enter the new group number(s).

		Please Read The Instructions Before Filling Out This Form.		Enrollment and Change Form	
<small>An Independent Licensee of the Blue Cross and Blue Shield Association</small>		<small>Please mail to: BCBS, P.O. Box 9145, North Quincy, MA 02171-9145</small>			
1. To Be Filled Out by Your Employer					
Company Name			Current Medical Group		Medical Group Transferring To
Current BCBS ID Number, if any	Requested Effective Date	Date of Hire	Initial Eligibility Date	Current Dental Group	Dental Group Transferring To
Type of Transaction		Remarks: (i.e., qualifying event for a new add, change to family, or further instruction)			
Add <input checked="" type="checkbox"/>	Change <input checked="" type="checkbox"/>	Cancel <input type="checkbox"/>			

Indicate whether you're adding, changing, or terminating the employee's coverage. If terminating, enter the appropriate code:

- 061 Left Employ
- 070 Deceased
- Over 65 (Transferring to HMO Senior Plan)
- 042 Over 65 (Transferring to Group Medex)
- 042 Over 65 (Transferring to Non-group Medex)
- 071 Moved From Service Area
- 061 COBRA End
- 041 Voluntary (Other than above)

(See Section 5 of this manual for further information about changing or terminating an employee's coverage.)

Enter the requested effective date of coverage, the employee's date of hire, and his or her initial eligibility date in these boxes.

Employee's current BCBSMA ID number, if already enrolled.

If your new hires are subject to a probationary period, please indicate the time frame in the "Remarks" section. Also, if the member's initial eligibility date is different from the date of hire, explain why here (e.g., marriage, birth, employee/retiree over age 65, etc.).

Call Your Account Service Representative for More Information on This Subject

ENROLLING EMPLOYEES IN A HEALTH PLAN

The employee should complete the following:

Tell Us About Yourself (Member 1)

The employee fills in his or her name, address, sex, date of birth, social security number, and phone number, as well as the provider number for the primary care physician (PCP) (managed care plans, **HMO** and **POS** only).* The PCP's provider number is listed in the provider directory of the chosen health plan.

What Product Are You Selecting?

The employee indicates the coverage desired. If the plan selected is not shown, the employee checks "Other" and writes in the plan name.

Kind of Membership

The employee should indicate whether he or she is joining as an individual, as a family, or other.

2. Tell Us About Yourself (Member 1)																
What product are you selecting?		HMO <input checked="" type="checkbox"/>	Health <input checked="" type="checkbox"/>	POS <input checked="" type="checkbox"/>	Other <input checked="" type="checkbox"/>	Medicare <input checked="" type="checkbox"/>	Medicaid <input checked="" type="checkbox"/>	Other (write name of Plan)	Kind of Membership (Medical)		Individual <input checked="" type="checkbox"/>	Family <input checked="" type="checkbox"/>	Kind of Membership (Dental)		Individual <input checked="" type="checkbox"/>	Family <input checked="" type="checkbox"/>
Your First Name				M.I.		Last Name				Sex		Date of Birth				
Street Address / P.O. Box No.						Apt. No.		City/Town		State		Zip Code				
Social Security No.				Home Telephone No. (include area code)				PCP Number		Is this your current PCP? Mark X, if yes. <input checked="" type="checkbox"/>						
Name of PCP				City/Town		Other Insurance? Y / N		Other Insurance Company Name				City/State				
Are you or anyone listed below covered by Medicare? *		Part A Effective Date		Part B Effective Date		Medicare No.		Actively Working Y / N				Retired Y / N				
Y / N		mm dd yyyy		mm dd yyyy		<input checked="" type="checkbox"/> 65+ <input checked="" type="checkbox"/> disabled <input checked="" type="checkbox"/> ESRD		If yes, date:								
* If you have not indicated yes or no regarding your Medicare status, you may receive a follow-up questionnaire.																
3. Tell Us About Your Spouse (Member 2)																
Spouse's First Name				M.I.		Spouse's Last Name				Sex		Date of Birth				
Social Security No.				Home Telephone No. (include area code)				PCP Number		Is this your current PCP? Mark X, if yes. <input checked="" type="checkbox"/>						
Name of PCP				City/State		Other Insurance? Y / N		Other Insurance Company Name				City/State				
Part A Effective Date		Part B Effective Date		Medicare No.		Actively Working Y / N				Retired Y / N						
mm dd yyyy		mm dd yyyy		<input checked="" type="checkbox"/> 65+ <input checked="" type="checkbox"/> disabled <input checked="" type="checkbox"/> ESRD		If yes, date:										

If the employee selects family or other coverage, he or she enters the spouse's information here.

If the employee or the employee's spouse has other health insurance coverage, he or she should fill in the insurer's name, city, and state.

If the employee and/or spouse is covered by Medicare, he or she should enter a "y" and fill in the Medicare number.

*If the employee, spouse, or dependents are enrolled in a managed care plan, and no PCP number is given, benefits cannot be guaranteed.

Call Your Account Service Representative for More Information on This Subject

ENROLLING EMPLOYEES IN A HEALTH PLAN

The *employee* should also complete the following:

Tell Us About Your Dependents

If the employee chooses family or other coverage, this section should be filled out completely for each child or other eligible dependent to be covered. A second Enrollment Change Form may be attached if necessary.

The employee indicates whether the dependents are full-time students. Supporting documentation (such as a paid tuition bill or a letter with the registrar's stamp) should be attached.

4. Tell Us About Your Dependents (Members 3, 4, and 5)					
Child's First Name	M.I.	Child's Last Name	Sex	Full-time student? Age 19 or over	Y / N
Date of Birth <small>mm dd yyyy</small>	Social Security No.	PCP Number	Name of PCP	Is this your current PCP? Mark X, if yes.	<input checked="" type="checkbox"/>
Child's First Name	M.I.	Child's Last Name	Sex	Full-time student? Age 19 or over	Y / N
Date of Birth <small>mm dd yyyy</small>	Social Security No.	PCP Number	Name of PCP	Is this your current PCP? Mark X, if yes.	<input checked="" type="checkbox"/>
Child's First Name	M.I.	Child's Last Name	Sex	Full-time student? Age 19 or over	Y / N
Date of Birth <small>mm dd yyyy</small>	Social Security No.	PCP Number	Name of PCP	Is this your current PCP? Mark X, if yes.	<input checked="" type="checkbox"/>
<p>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 authorize Blue Cross and Blue Shield to obtain medical records or information from the Social Security Administration, Medicare contractors, other health care programs, insurers or any government agency to verify eligibility, claims payment information or properly coordinate benefits.</p>					
Employee's Signature		Date	Employee's Signature		Date

Be sure you and the employee sign and date the form.

Each family member can choose a different PCP (see * note, p. 2-10).

Please note: this paragraph tells you why Blue Cross Blue Shield of Massachusetts requires signatures.

Call Your Account Service Representative for More Information on This Subject

ENROLLING EMPLOYEES IN A HEALTH PLAN

Please note: We need birth dates of the subscriber, spouse, and eligible dependents to issue identification cards. Both the employee and the employer must sign and date the application.

Unsigned applications cannot be processed and will be returned.

The following example shows how to add a subscriber or employee to your plan.

BlueCross BlueShield of Massachusetts		Please Read The Instructions Before Filling Out This Form.		Enrollment and Change Form	
An Independent Licensee of the Blue Cross and Blue Shield Association				Please mail to: BCBS, P.O. Box 9145, North Quincy, MA 02171-9145	
1. To Be Filled Out by Your Employer					
Company Name Johnson Company		Current Medical Group 0012345		Medical Group Transferring To	
Current BCBS ID Number, if any 03 01 2000		Date of Hire 12 01 1999		Initial Eligibility Date 12 01 1999	
Type of Transaction <input checked="" type="checkbox"/> Add <input checked="" type="checkbox"/> Change <input type="checkbox"/> Cancel		Remarks (S.A., qualifying event for a new add, change to family, or further instruction) New hire - Completed three month probationary period			
2. Tell Us About Yourself (Member 1)					
What product are you selecting? <input checked="" type="checkbox"/> Individual <input checked="" type="checkbox"/> Family <input checked="" type="checkbox"/> Other		Kind of Membership (Medical) <input checked="" type="checkbox"/> Individual <input checked="" type="checkbox"/> Family		Kind of Membership (Dental) <input type="checkbox"/> Individual <input type="checkbox"/> Family	
Your First Name Debra		Last Name A Jackson		Sex F	
Street Address / P.O. Box No. 15 Union Street		City/Town Everett		State / Zip Code MA 02149	
Social Security No. 021340000		Home Telephone No. (include area code) (617) 555-1212		Other Insurance Company Name XYZ Insurance Co	
Name of PCP Dr. John Taunton, MA		PCP ID Number 700J12345		Is this your current PCP? Mark X, if yes. <input checked="" type="checkbox"/>	
Are you or anyone listed below covered by Medicare? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		Part A Effective Date 03 01 2000		Part B Effective Date 03 01 2000	
		Medicare No. <input type="checkbox"/> 65+ <input type="checkbox"/> disabled <input checked="" type="checkbox"/> ESRD		Actively Working Y / N <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
* If you have not indicated yes or no regarding your Medicare or other insurance status, you may receive a follow-up questionnaire.					
3. Tell Us About Your Spouse (Member 2)					
Spouse's First Name Sean		Spouse's Last Name L Jackson		Sex M	
Social Security No. 012340000		Home Telephone No. (include area code) (417) 555-1212		Other Insurance Company Name XYZ Insurance Co	
Name of PCP Dr. John Taunton, MA		PCP ID Number 700J12345		Is this your current PCP? Mark X, if yes. <input checked="" type="checkbox"/>	
Part A Effective Date 03 01 2000		Part B Effective Date 03 01 2000		Medicare No. <input checked="" type="checkbox"/> 65+ <input type="checkbox"/> disabled <input type="checkbox"/> ESRD	
				Actively Working Y / N <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
4. Tell Us About Your Dependents (Members 3, 4, and 5)					
Child's First Name Tiffany		Child's Last Name A Jackson		Sex F	
Date of Birth 07 01 1996		Social Security No. 012340000		PCP ID Number 700J12345	
		Name of PCP Dr. John		Is this your current PCP? Mark X, if yes. <input checked="" type="checkbox"/>	
Child's First Name		Child's Last Name		Sex	
Date of Birth		Social Security No.		PCP ID Number	
				Name of PCP	
				Is this your current PCP? Mark X, if yes. <input type="checkbox"/>	
Child's First Name		Child's Last Name		Sex	
Date of Birth		Social Security No.		PCP ID Number	
				Name of PCP	
				Is this your current PCP? Mark X, if yes. <input type="checkbox"/>	
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 authorize Blue Cross and Blue Shield to obtain medical records or information from the Social Security Administration, Medicare contractors, other health care programs, insurers or any government agency to verify eligibility, claims payment information or properly coordinate benefits.					
Employee's Signature Debra A. Jackson		Date 2/20/00		Employer's Signature [Signature]	
				Date 2/20/00	

Call Your Account Service Representative for More Information on This Subject

ENROLLING EMPLOYEES IN A HEALTH PLAN

Medicare Secondary Payer Compliance Project

Federal regulations require us to determine if any members are also covered under Medicare. Whenever an employee is added, adds a spouse or dependent, changes groups, or changes employers, this form is sent to determine Medicare coverage status.

**Blue Cross Blue Shield
of Massachusetts**

Dear Subscriber,

We need to know if you or any of your covered family members are covered under the federal Medicare health insurance Plan. This information is essential for us to qualify and will be used to ensure compliance with federal law. So please take a moment to complete this form and return it to your advisor in the enclosed envelope. If you need assistance call our dedicated line at 1-800-850-8891.

Thank you for being the first to complete this questionnaire and, most importantly, thank you for being a Blue Cross and Blue Shield member.

Section 1

Are you, or any member of your family, also covered by either Medicare or Blue Cross and Blue Shield of Massachusetts?

Yes Please complete Questions 2 and 3, sign, date, return, and return to us. **No** If no, please complete and return to your advisor and return to us.

Section 2

All the categories of health insurance plans, check the box that reflects your coverage:

<input type="checkbox"/> Active Employee	<input type="checkbox"/> Spouse/Partner/Spouse of Active Employee
<input type="checkbox"/> Deceased Employee	<input type="checkbox"/> Spouse/Partner/Spouse of Deceased Employee
<input type="checkbox"/> Retired Employee	<input type="checkbox"/> Spouse/Partner/Spouse of Retired Employee
<input type="checkbox"/> Retired (with COBRA) <input type="checkbox"/> COBRA	<input type="checkbox"/> Other, please explain _____
<input type="checkbox"/> Spouse/Partner	

Section 3 - Complete the following for covered members who have Medicare.

Medicare Member's First Name: _____ Medicare Part A Insurance (Medicare Part A) (MAY/NOV): _____ Medicare Type: <input type="checkbox"/> Part A <input type="checkbox"/> Part B <input type="checkbox"/> COBRA (and other Part A coverage) (check if does not)	Medicare Member's Last Name: _____ Medicare Part B Insurance (Medicare Part B) (MAY/NOV): _____ Medicare Type: <input type="checkbox"/> Part A <input type="checkbox"/> Part B <input type="checkbox"/> COBRA (and other Part B coverage) (check if does not)
Medicare Member's First Name: _____ Medicare Part A Insurance (Medicare Part A) (MAY/NOV): _____ Medicare Type: <input type="checkbox"/> Part A <input type="checkbox"/> Part B <input type="checkbox"/> COBRA (and other Part A coverage) (check if does not)	Medicare Member's Last Name: _____ Medicare Part B Insurance (Medicare Part B) (MAY/NOV): _____ Medicare Type: <input type="checkbox"/> Part A <input type="checkbox"/> Part B <input type="checkbox"/> COBRA (and other Part B coverage) (check if does not)

Subscriber Signature _____ Date _____

Call Your Account Service Representative for More Information on This Subject

ENROLLING EMPLOYEES IN A HEALTH PLAN

AccountLink® Products

AccountLink is the name we've given to our innovative programs and systems that let you update your enrollment information yourself. Our AccountLink programs eliminate the need to submit information to us on paper, allowing you to electronically enter and update your enrollment information.

DirectLink™

DirectLink is the on-line access product that provides you with access to the Blue Cross Blue Shield enrollment database. It features pop-up screens for inquiry and data entry. This product uses personal computer application software and modem to dial into the Blue Cross Blue Shield database.

FileLink®

FileLink is the account-batch maintenance facility that features a full-file or activity-only update capability. We will systematically take in data from your payroll/HR system, compare it to our enrollment eligibility database, and make the appropriate changes.

These programs are available to certain size accounts. Please contact your sales representative for more information about these products, or to arrange for an on-site demonstration.

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