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





1. To Be Filled Out by You	r Employ	er											
Municipality Name						Current Medical Group #			Medical Group # Transferring to				
Current BCBS ID #,	Reque	equested Effective Date				Current Dental Group #			Dental Group # Transferring to				
If Any	MM	DD	D YYYY										
Type of Transaction ☐ ADD		Remarks: (e.g., qualifying event for a new add, change to family, or other instruction)											
□ CANCEL □ TRANSFER		☐ Open Enrollment ☐ Loss of Coverage (HIPAA Continuation of Coverage Letter required) ☐ Other:											
2. Yourself													
What products?									Membership Type (Dental)				
☐ Medex with Blue Medicare Rx (Part D)						☐ Dental Blue			☐ Individual				
☐ Managed Blue for Seniors with Blue Medicare Rx									☐ Family				
First Name		M.I. Las			st Name			Sex			Date of Birth		
Street Address/ P.O. Box #		Apt. # City			y/Town			State			ZIP Code		
Home Phone	Co (ell Pl	hone)		Email								
Social Security # REQ			Insuran N 🗖	ce?	Other Insurance Company Name			Member Identification Number					
PCP ID # (see instruction	N	ame	of PCP		City / State				Is this your current PCP? Y□ / N□				
Part A Effective Date	rt B Eff	ectiv	e Date		Medicare #		☐ 65+ ☐ Disabled ☐ ESRD						
MM DD YYYY	M	M D	D	YYYY	ľ				If Retired, Date				
3. Signatures (Employer &	& Employ	ee)											
The information here is tion to enroll me and m subscriber certificate or that apply to my health information about me to with law. I acknowledge information in "Our Co	y depen benefit care pla o carry o e that I r	dents o booklet n. I und ut its bu nay obt	r to not provide to the provide to t	make che vided by and that ess, and urther in	iang y m t Bl tha nfor	ges to my memby employer to u ue Cross and Bl t it may use and rmation about the	ner ind lue l di he	ship. I un lerstand n Shield m sclose tha collection	derany b ay c at in , us	star oene obta ofor e, a	efits and efits and in pers mation nd disc	I should d any restonal and in accordal color of the colo	read the trictions medical dance f my
Retiree's Signature			Date		Employer's	Employer's Signature			Date				