



Tell Us About You		Current BCBS ID number, if any			
Last Name		First name		M.I.	
Home Address: Number and Street			Apt. #/P.O. Box		
City		State		Zip Code	
Home Telephone		Work Telephone		Effective Date (MM/DD/YY)	
Department Employee Number		Department		Date of Hire (MM/DD/YY)	
		Employee #			
Please Check the boxes that apply:		CANCEL MEMBERSHIP		Your Membership Choices	
NEW MEMBERSHIP <input type="checkbox"/> Annual Reopening <input type="checkbox"/> New Enrollment <input type="checkbox"/> COBRA <input type="checkbox"/> Loss of Insurance		<input type="checkbox"/> Left Employ <input type="checkbox"/> Deceased <input type="checkbox"/> Moved From Service Area <input type="checkbox"/> COBRA End <input type="checkbox"/> Voluntary (Other than above) <input type="checkbox"/> No Longer Eligible			
CHANGE MEMBERSHIP <input type="checkbox"/> Name/Address Change <input type="checkbox"/> Add Dependent <input type="checkbox"/> Terminate Dependent <input type="checkbox"/> Transfer		Check Here if you are enrolling in: <input type="checkbox"/> HMO-Network Blue NE <input type="checkbox"/> PPO-Blue Care Elect Preferred <input type="checkbox"/> Medex 2			
Kind of Membership		Current Group #		If Transferring, New Group #	
<input type="checkbox"/> Individual <input type="checkbox"/> Family					
List ALL Family Members to Be Covered				Sex (Circle One)	
				Primary Care Physician (PCP) Name and Number (Refer to Provider Directory) - HMO only Check <input type="checkbox"/> the box if you currently use this physician	
Your Name	Last Name	First Name	M.I.	PCP Name:	
Date of Birth (MM/DD/YY)	Social Security #	M	F	PCP #	City / State <input type="checkbox"/>
Spouse's Name	Last Name	First Name	M.I.	PCP Name:	
Date of Birth (MM/DD/YY)	Social Security #	M	F	PCP #	City / State <input type="checkbox"/>
Dependent Information - Please Circle Yes (Y) or No (N) if Dependent Is Disabled					
Dependent	Last Name	First Name	M.I.	PCP Name:	
Date of Birth (MM/DD/YY)	Social Security #	M	F	Y	N <input type="checkbox"/>
Dependent	Last Name	First Name	M.I.	PCP Name:	
Date of Birth (MM/DD/YY)	Social Security #	M	F	Y	N <input type="checkbox"/>
Dependent	Last Name	First Name	M.I.	PCP Name:	
Date of Birth (MM/DD/YY)	Social Security #	M	F	Y	N <input type="checkbox"/>
Dependent	Last Name	First Name	M.I.	PCP Name:	
Date of Birth (MM/DD/YY)	Social Security #	M	F	Y	N <input type="checkbox"/>
Tell Us About Your Other Insurance	Do you or any other member of your family have any other medical or dental coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please fill in the information below.		Do you or any covered family member have Medicare Coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No		
	Name of Other Insurance Company		Name		Is this person a Retiree? <input type="checkbox"/> Yes <input type="checkbox"/> No
	Name of Subscriber (Policy Holder)	Policy or ID #	Medicare #	Medicare Part A Effective Date (Hospital)	Medicare Part B Effective Date (Medical)
Remarks					
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.					
Employee's Signature		Date (MM/DD/YY)	Employer's Signature		Date (MM/DD/YY)