

1. To Be Filled Out by Your Employer						
Company Name <b>Teamsters Local 170</b>				Current Medical Group #	Medical Group # Transferring To	
Current BCBS ID Number, if any	Requested Effective Date MM DD YYYY	Date of Hire MM DD YYYY	Initial Eligibility Date MM DD YYYY	Current Dental Group #	Dental Group # Transferring To	
Type of Transaction Add <input checked="" type="checkbox"/> Change <input checked="" type="checkbox"/> Cancel <input type="checkbox"/>		Remarks: (i.e., qualifying event for a new add, change to family, or further instruction)				

2. Tell Us About Yourself (Member 1)										
What product are you selecting?	HMO Blue <input type="checkbox"/>	Network Blue <input checked="" type="checkbox"/>	Blue Choice <input checked="" type="checkbox"/>	Dental Blue <input checked="" type="checkbox"/>	HMO Blue New England <input checked="" type="checkbox"/>	Blue Choice New England <input checked="" type="checkbox"/>	PPO <input checked="" type="checkbox"/>	Other (write name of Plan) <input checked="" type="checkbox"/>	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 MM DD YYYY				
Street Address / P.O. Box No.			Apt. No.	City/Town		State	Zip Code			
Social Security No.	Home Telephone No. (include area code)		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? *	Y / N	Part A Effective Date MM DD YYYY	Part B Effective Date MM DD YYYY	Medicare No.	Actively Working Y / N		Retired Y / N 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			M.I.	Spouse's Last Name			Sex	Date of Birth MM DD YYYY		
Social Security No.	Home Telephone No. (include area code)		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"/>			
Part A Effective Date MM DD YYYY	Part B Effective Date MM DD YYYY		Medicare No.	Actively Working Y / N		Retired Y / N If yes, date:				

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"/>		

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.