HMO Blue® Direct & HMO Basic Blue Direct Application

BlueCross BlueShield of Massachusetts

An Independent Licensee of the Blue Cross and Blue Shield Association

Remember that you are eligible for coverage only if you meet each of the following eligibility requirements

- You are a resident of Massachusetts, you actually live in Massachusetts, and
- You meet the Plan's requirements regarding residence within the Plan's approved service area, and
- You are not enrolled in Medicare or Medicaid.

For a complete listing of all standard benefits, please refer to your Summary of Benefits.

Waiting Period

The benefits available under this plan, other than for emergency services, are not available until you have been covered for 180 consecutive days. The length of time you were previously covered under another health care plan can be applied to reduce or waive this 180-day period, as required by state or federal law.

Upgrading Your Coverage

If you enroll in HMO Basic Blue Direct and wish to upgrade your coverage to HMO Blue Direct or PPO Blue Direct, a waiting period may apply. Call Member Service for further information.

Premium Rate Increases

- Premium rates for these plans are based on place of residence and age.
- The rate is based on the age of the oldest applicant.
- Premium rates for these plans are subject to change on December 1st of each year. Therefore, your premium will also change on December 1st if you move your residence during a particular year or reach age 36, 41, 46, 51, 56, or 61.

How to Enroll in either HMO Blue Direct or HMO Basic Blue Direct

Step 1 Please complete all the information on this form, and sign in the space indicated.

Step 2 If you've had prior insurance and would like your waiting period waived or reduced, you will need to submit a Proof of Prior Coverage. This is a letter from either your prior insurance carrier or your prior employer, which indicates the dates covered. If you've had previous coverage the 180-day waiting period will be reduced or waived as required with your Proof of Prior Coverage documentation as long as you make this application within 63 days of your last date of coverage.

Step 3 Mail application with Proof of Prior Coverage (if applicable) to the address below or fax it to us at **1-617-246-3633.**

Blue Cross Blue Shield of Massachusetts
Direct Sales 09/8B
100 Hancock Street
North Quincy, MA 02171-1752

No payment needed with application. We will bill you once we receive your completed, signed application, and we confirm your eligibility.

Over

Choose a Product

❑ **HMO Blue Direct**

❑ **HMO Basic Blue Direct (No prescription drug coverage)**

Subscriber Information

Previous Blue Cross Blue Shield of Massachusetts member? *Yes* ☐ *No* ☐ ID # _____

Social Security Number_____Primary Language_____

Type of Coverage Individual ☐ Family ☐ Single parent with dependent children ☐ Couple ☐

_____ Male ☐ Female ☐ Date of Birth_____

Subscriber's Last Name First Name M. I.
(oldest applicant must be the subscriber)

_____

Street Address City/Town State Zip

Marital Status_____Home Telephone_____Work Telephone_____

Name of Primary Care Physician_____PCP# _____
(see *HMO Blue Direct Provider Directory*)

Are you currently enrolled in Medicare or Medicaid? *Yes* ☐ *No* ☐

Dependent Information

First **Middle** **Last (if different)**

Spouse Sex M ☐ F ☐ Date of Birth

Name of Primary Care Physician_____ *Currently enrolled in Medicare or Medicaid Yes* ☐ *No* ☐

1. Child Sex M ☐ F ☐ Date of Birth

Over 19 and handicapped Yes ☐ *No* ☐ *Currently a student over age 19 Yes* ☐ *No* ☐

Name of Primary Care Physician_____ *Currently enrolled in Medicare or Medicaid Yes* ☐ *No* ☐

2. Child Sex M ☐ F ☐ Date of Birth

Over 19 and handicapped Yes ☐ *No* ☐ *Currently a student over age 19 Yes* ☐ *No* ☐

Name of Primary Care Physician_____ *Currently enrolled in Medicare or Medicaid Yes* ☐ *No* ☐

3. Child Sex M ☐ F ☐ Date of Birth

Over 19 and handicapped Yes ☐ *No* ☐ *Currently a student over age 19 Yes* ☐ *No* ☐

Name of Primary Care Physician_____ *Currently enrolled in Medicare or Medicaid Yes* ☐ *No* ☐

Do you, your spouse, or your dependents currently have any other health or dental insurance? *Yes* ☐ *No* ☐

If Yes, name of insurance company (or health plan)_____Policy Number_____

Was drug coverage included? *Yes* ☐ *No* ☐ Last date of coverage in previous health insurance plan_____

You may need to provide documentation of the termination date of coverage.

I understand that I (and, as applicable, my dependents) am eligible for Direct Pay coverage due to the fact that I am a resident and actually live in Massachusetts and am not enrolled in either or both parts of Medicare, or Medicaid. The information supplied on this form is true and complete.
I grant Blue Cross and Blue Shield of Massachusetts, Inc. or Blue Cross and Blue Shield of Massachusetts HMO, Inc., depending on my choice of plan, any legal right that I and/or my covered dependents have to recover the cost of services for an illness or injury caused by someone else when these services have been or will be paid by Blue Cross and Blue Shield. I understand that Blue Cross and Blue Shield may obtain personal and medical information about me and/or my covered dependents to carry out its business, and that it may use and disclose that information in accordance with the law. I acknowledge that I may obtain further information about the collection, use, and disclosure of my and/or my covered dependents information in "Our Commitment to Confidentiality," the Blue Cross and Blue Shield notice of privacy practices. This information may be obtained upon request or by visiting www.bluecrossma.com. I understand that the benefits for which I and/or my covered dependents are eligible are those described in the applicable subscriber certificate. I understand that benefits and premium rates are subject to change as allowed by state law. I understand that enrollment in this plan is contingent upon payment of premium.

Date_____Signature_____

NOTE: If you or any of your enrolled dependents: (a) obtain a health care benefit or payment from Blue Cross and Blue Shield of Massachusetts, Inc., that you know you are not entitled to receive or be paid; or (b) knowingly present or cause to be presented, with fraudulent intent, a claim that contains a false statement, you can be liable to Blue Cross and Blue Shield for the full amount of the health care benefit or payment made and for reasonable attorney's fees and costs, including cost of investigation.

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