Please Read The Instructions Before Filling Out This Form.

Please **PRINT CLEARLY** using blue or black ink to avoid coverage delay or type in information.

MASSACHUSETTS

Blue Cross Blue Shield of Massachusetts ia an Independent Licencee of the Blue Cross and Blue Shield Association

Enrollment and Change Form

Please mail to: P.O. Box 986001, Boston, MA 02298 or fax 617-246-7531

1. To Be Filled Out by Your Employer

Company Name	Current Medical Group #:	Medical Group #, Transferring To

Current BCBS ID #, If any	Requested Effective Date MM DD YYYY	Date of Hire MM DD YYYY	Current Dental Group #:	Dental Group #, Transferring To

Type of Transaction
- ☐ ADD
- ☐ CHANGE
- ☐ TRANSFER
- ☐ CANCEL

(If canceling, please see instructions for three digit termination code.) ☐☐☐

Remarks: (i.e., qualifying event for a new add, change to family or other instruction)

- ☐ Open Enrollment
- ☐ New Hire
- ☐ COBRA

Change to Family
- ☐ Add Spouse
- ☐ Add Dependent

- ☐ Loss of Coverage (HIPAA Continuation of Coverage Letter Required)
- ☐ Other_____

2. Tell Us About Yourself (Member 1)

What Products are you selecting?
- ☐ PPO Blue
- ☐ Dental Blue
- ☐ HMO Blue New England
- ☐ HMO Select Network $250 Ded.

Kind of Membership (Medical)
- ☐ Individual
- ☐ Family

Kind of Membership (Dental)
- ☐ Individual
- ☐ Family

Your First Name	M.I.	Last Name	Sex	Date of Birth

Street Address / P.O. Box #:	Apt. #:	City / Town	State	Zip Code

Social Security #:	Telephone #: (area code) ( )	Other Insurance? * Y ☐ / N ☐	Other Insurance Company Name	City / State

PCP ID #: (see instructions)	Name of PCP	City/State	Is this your current PCP? Mark X, if yes. ☐

Are you Covered by Medicare? * Y ☐ / N ☐	Part A Effective Date MM DD YYYY	Part B Effective Date MM DD YYYY	Part D Effective Date MM DD YYYY	Medicare #:	Actively Working Y ☐ / N ☐
				☐65+ ☐ Disabled ☐ESRD	If Retired, Date:

3. Tell Us About (Member 2)

Please check one: ☐ Spouse ☐ Domestic Partner ☐ Divorced Spouse (court ordered)

Member 2's First Name	M.I.	Last Name	Sex	Date of Birth

Street Address / P.O. Box #:	Apt. #:	City / Town	State	Zip Code

Social Security #:	Telephone #: (area code) ( )	Other Insurance? * Y ☐ / N ☐	Other Insurance Company Name	City / State

PCP ID #: (see instructions)	Name of PCP	City/State	Is this your current PCP? Mark X, if yes. ☐

Is Member 2 Covered by Medicare? * Y ☐ / N ☐	Part A Effective Date MM DD YYYY	Part B Effective Date MM DD YYYY	Part D Effective Date MM DD YYYY	Medicare #:	Actively Working Y ☐ / N ☐
				☐65+ ☐ Disabled ☐ESRD	If Retired, Date:

**** If you have not indicated Yes or No regarding your Medicare or other insurance status, you may receive a follow-up questionnaire.***

4. Tell Us About Your Dependents (Member 3, 4, and 5)

Dependent's First Name 3.)	M.I.	Last Name	Sex	Full-time student? Age 19 or Over Y ☐ / N ☐

Social Security #:	Date of Birth	PCP ID #: (see instructions)	Name of PCP	Is this your current PCP? Mark X, if yes. ☐

Dependent's First Name 4.)	M.I.	Last Name	Sex	Full-time student? Age 19 or Over Y ☐ / N ☐

Social Security #:	Date of Birth	PCP ID #: (see instructions)	Name of PCP	Is this your current PCP? Mark X, if yes. ☐

Dependent's First Name 5.)	M.I.	Last Name	Sex	Full-time student? Age 19 or Over Y ☐ / N ☐

Social Security #:	Date of Birth	PCP ID #: (see instructions)	Name of PCP	Is this your current PCP? Mark X, if yes. ☐

Please check if you are using separate forms for additional dependent children. ☐ Total # of Dependents : _____

5. Select Personal Savings Account (Blue Healthcare Bank Members Only)

☐ HSA	Start Date:	End Date:	FSA GOAL AMOUNTS: (Please see instructions for maximum limits.)
☐ FSA – Health	Start Date:	End Date:	Health $:
☐ FSA – Dep.	Start Date:	End Date:	Dependent Care $:

6. Signature (Employer & Employee)

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 Employer's Signature Date

MASSACHUSETTS

Blue20/20

Application / Change Form

☐ **New Enrollee**
(Please complete A, C, D, and E)

☐ **Change Request**
(For changes, complete Sections A, B, and all other applicable sections. Plan changes can only be made at Open Enrollment or due to a qualifying event.)

☐ **Termination Date:** _____

Please print clearly.
Please use a black or blue pen.

Blue 20/20 Group No.

A. Employee Information

Name of Employer:		Effective Date:	Dept./Division:
Social Security Number:	Date of Birth:	Sex: ☐ Male ☐ Female	
Last Name:	First Name:	MI:	Marital Status: ☐ Single ☐ Married
Mailing Address:		City:	State: / Zip Code:
Date of Hire:	Home Phone Number:	Work Phone Number:	Email Address:

B. If Making a Change from Previous Enrollment

Check All That Apply:

- ☐ Name Change
- ☐ Employee SSN Correction
- ☐ Add/Remove Dependent
- ☐ Address/Telephone Number Change
- ☐ Date of Birth Correction
- ☐ Late Enrollee
- ☐ Other:

Add Dependent(s):

	Date of Occurrence
☐ Marriage	_____
☐ Domestic Partner	_____
☐ Newborn (up to age 1)	_____
☐ Adoption	_____
☐ Court Order	_____
☐ Loss of Coverage	_____
☐ Other	_____

☐ **Remove Dependent(s)** _____

Date: _____

Reason:

Reinstate Coverage:

Date: _____

Reason:

Terminate Coverage:

Date: _____

Reason:

Blue20/20

C. Coverage Selection

Options Selected: ☐ Employee ☐ Employee plus Spouse or Domestic Partner
☐ Employee plus One or More Children ☐ Family

D. Family Information—Complete for anyone taking or dropping Blue 20/20 Coverage*

	Name (First, MI, Last Name)	Social Security Number	Date of Birth mm/dd/yyyy	Relationship	Sex
☐ Add / ☐ Delete					☐ M ☐ F
☐ Add / ☐ Delete					☐ M ☐ F
☐ Add / ☐ Delete					☐ M ☐ F
☐ Add / ☐ Delete					☐ M ☐ F
☐ Add / ☐ Delete					☐ M ☐ F
☐ Add / ☐ Delete					☐ M ☐ F
☐ Add / ☐ Delete					☐ M ☐ F

*Application does not guarantee enrollment.
Eligibility Notes:
1. Employees are eligible for coverage if they meet the definition of an eligible employee as defined by their employer and Blue Cross Blue Shield of Massachusetts.
2. Domestic Partners are eligible for coverage if they meet the definition of a Domestic Partner and if allowed by the employer.
3. Dependent Children are eligible for coverage up to age 26.

E. Statement of Understanding

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 vision plan.

Signature of Employee _____ Date _____

Visit us at blue2020ma.com

Blue Cross Blue Shield of Massachusetts complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex, sexual orientation or gender identity.

ATTENTION: If you don't speak English, language assistance services, free of charge, are available to you. Call Member Services at the number on your ID Card **(TTY: 711)**.

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia con el idioma. Llame al número de Servicio al Cliente que figura en su tarjeta de identificación **(TTY: 711)**.

ATENÇÃO: Se fala português, são-lhe disponibilizados gratuitamente serviços de assistência de idiomas. Telefone para os Serviços aos Membros, através do número no seu cartão ID **(TTY: 711)**.

182703M
55-0554 (07/18) 2.5C

BOSTON MUTUAL LIFE INSURANCE COMPANY **1-800-669-2668 x700**

120 Royall Street • Canton, MA 02021

PLEASE PRINT OR TYPE

GROUP BENEFITS ENROLLMENT FORM

EMPLOYEE / FAMILY INFORMATION

0001696-00001 ***Town of Georgetown, Massachusetts***

Group Number-Division Number | Employer/Policyholder | Dept. ID

Employee Name *(Last, First, Middle)* | Social Security Number

Home Address *(Street, City, State, Zip)* | ( ) Telephone #

Gender *(M/F)* | Occupation or Job Title | Date of Birth | Age | PAYROLL TYPE: ☐ Monthly ☐ Bi-Weekly ☐ Annual | Earnings: $

Average Hours Worked | Date of Hire | or Date of Full Time Employment if different | Effective Date | State | Class | Rate Basis

Spouse *(Last, First, Middle)* | Gender *(M/F)* | Date of Birth | Age | No. of Dependents

LIFE - DISABILITY

ONLY ELECT BOSTON MUTUAL COVERAGES MADE AVAILABLE TO YOU THROUGH YOUR EMPLOYER.

BASIC	YES	NO	Insurance Amount
LIFE	☐	☐	$ ***$5,000.00***
AD&D	☐	☐	$ ***$5,000.00***

BENEFICIARY

BENEFICIARY(IES) FOR LIFE AND/OR AD&D BENEFITS: ***(Attach Additional Beneficiaries on a signed and dated separate sheet)***

Primary Beneficiary(ies):	Residential Address	Date of Birth	Social Security #	Tel. #	Relationship	% of Benefit
Contingent Beneficiary(ies):						

If you designate more than one beneficiary, please be sure the total percentages of benefit equals 100%. If you do not designate a percentage payable for each beneficiary, the total proceeds payable will be divided equally among each beneficiary. If an insured dependent dies, we will pay the proceeds to you.

Please complete as much beneficiary information as you can provide.

SIGNATURE

REFUSAL OF INSURANCE

I hereby certify that I have been given an opportunity to participate in the Group Insurance Plan offered by my Employer *(or the Association with whom I am affiliated)* and insured by Boston Mutual Life Insurance Company and that I have declined to do so with respect to:

☐ Life & AD&D

I further understand that if I desire to participate in the Plan at a later date with respect to the coverage(s) checked, I must furnish, at my own expense, evidence of insurability satisfactory to Boston Mutual Life Insurance Company.

Signature of Employee _____ Date _____

Signature of Witness _____ Date _____

EMPLOYEE SIGNATURE REQUIRED

I apply for the insurance for which I am now eligible *(or for which I may become eligible)* under the provisions of the Group Policy or Group Policies issued to my employer by the Boston Mutual Life Insurance Company and authorize deductions, if any, from my earnings of the required premium contribution toward the cost of the insurance. *I understand that if I am disabled on the date my insurance would otherwise become effective, I shall only become insured on the date I return to active full-time work.* I further understand that if I decline insurance coverage for which I am now eligible and I desire to participate in the plan at a later date, I must furnish, at my own expense, evidence of insurability satisfactory to Boston Mutual Life Insurance Company.

Signature of Employee _____ Date _____

Participant Enrollment
Governmental 457(b) Plan

Massachusetts Deferred Compensation SMART Plan 98966-01

Participant Information

Last Name | First Name | MI

Social Security Number

Mailing Address

E-Mail Address

City | State | Zip Code

❑ Married ❑ Unmarried ❑ Female ❑ Male

( ) Home Phone ( ) Work Phone

Mo Day Year — Date of Birth

Mo Day Year — Date of Hire

Annual Income

❑ Check box if you prefer to receive quarterly account statements in Spanish.

Do you have a retirement savings account with a previous employer or an IRA? ❑ Yes ❑ No

Would you like help consolidating your other retirement accounts into your account with Empower Retirement?* ❑ Yes, I would like a representative to call me at phone #_____-_____-_____ to review my options and assist me with the process. The best time to call is _____ to_____ A.M./ P.M. (circle one - available 8:00 A.M. to 8:00 P.M. EST). *Rollovers are subject to your Plan's provisions.

Statement Delivery - If an e-mail address is on file for your account, your statement will be delivered electronically. If you prefer to receive a printed statement, you may elect to change your preference through your online account or by calling 1-877-457-1900.

Payroll Information

❑ I elect to contribute $_____ or _____% ($1.00 - $19,500.00 or 1% - 100%) per pay period of my compensation as before-tax contributions to the Governmental 457(b) Deferred Compensation Plan until such time as I revoke or amend my election.

❑ I elect to contribute $_____ or _____% ($1.00 - $19,500.00 or 1% - 100%) per pay period of my compensation after-tax as a designated Roth contribution to the Governmental 457(b) Deferred Compensation Plan until such time as I revoke or amend my election.

Note: The total of your before-tax and Roth deferrals cannot exceed 100% or $19,500.00. Your before-tax and Roth deferrals must be specified consistently (both as a percent or both as a dollar amount). If I am 50 years of age or older and I am eligible for a catch-up contribution, I understand I may exceed this total.

Payroll Effective Date: Mo Day Year

Payroll Center Name

Payroll Center Number

Division Name

Division Number

Scheduled Annual Increase

I elect to have a scheduled annual contribution increase to the Plan the following amount(s) or percentage(s) of my eligible compensation indicated below *(per pay period)*:

Please complete the following information:

❑ Before-Tax Starting Amount $_____ or _____% per pay check
To a Maximum Amount $ _____ or _____% per pay check ($1.00 - $19,500.00 or 1% - 100%)
Select the increment to increase annually $_____ or _____%

❑ Roth Starting Amount $_____ or _____% per pay check
To a Maximum Amount $ _____ or _____% per pay check ($1.00 - $19,500.00 or 1% - 100%)
Select the increment to increase annually $_____ or _____%

Last Name	First Name	M.I.	Social Security Number	98966-01 Number

Managed Accounts Service Information

The Managed Accounts Service provided by Advised Assets Group, LLC ("AAG") will automatically direct your investment election for future contributions and will rebalance your account quarterly, if necessary. This election will be effective the day of receipt if received in good order by Service Provider prior to New York Stock Exchange market close. Any request received after New York Stock Exchange market close will be considered received the next business day. By electing the Managed Accounts Service, I agree to the fees associated with this service and understand the fee will be deducted from my account on a quarterly basis in accordance with the attached Managed Accounts Agreement. If you prefer to make your own investment decisions and not participate in this service, simply select the Select My Own Investment Options box and enter your investment instructions in the Investment Option Information section.

Managed Accounts Service:

❑ By checking this box, I elect to have my account professionally managed by Advised Assets Group, LLC ("AAG") until such time as I revoke or amend my election.

-OR-

Select My Own Investment Options:

❑ I elect to direct my own investments.
I understand and agree that my employer and other Plan fiduciaries will not be liable for the results of my personal investment decisions.

Make your investment election for future deposits in the Investment Option Information section.

Do not complete this section if you are electing to enroll in the Managed Accounts Service.

Investment Option Information (applies to all contributions) - Please refer to your communication materials for information regarding each investment option.

I understand that funds may impose redemption fees on certain transfers, redemptions or exchanges if assets are held less than the period stated in the fund's prospectus or other disclosure documents. I will refer to the fund's prospectus and/or disclosure documents for more information.

INVESTMENT OPTION

NAME	TICKER	CODE	%
SMARTPath Retirement Allocation Fund	N/A	SMPT00	_____
SMARTPath 2005 Retirement Fund	N/A	SMPT05	_____
SMARTPath 2010 Retirement Fund	N/A	SMPT10	_____
SMARTPath 2015 Retirement Fund	N/A	SMPT15	_____
SMARTPath 2020 Retirement Fund	N/A	SMPT20	_____
SMARTPath 2025 Retirement Fund	N/A	SMPT25	_____
SMARTPath 2030 Retirement Fund	N/A	SMPT30	_____
SMARTPath 2035 Retirement Fund	N/A	SMPT35	_____
SMARTPath 2040 Retirement Fund	N/A	SMPT40	_____
SMARTPath 2045 Retirement Fund	N/A	SMPT45	_____
SMARTPath 2050 Retirement Fund	N/A	SMPT50	_____
SMARTPath 2055 Retirement Fund	N/A	SMPT55	_____
SMARTPath 2060 Retirement Fund	N/A	SMPT60	_____
International Stock Index Fund	N/A	SVEAFT	_____

INVESTMENT OPTION

NAME	TICKER	CODE	%
International Equity Fund	N/A	MASIEF	_____
SMART Real Return Fund	N/A	MASPRR	_____
Real Estate REIT Fund	N/A	IVERES	_____
Small Company Stock Fund	N/A	WELASC	_____
Small Company Stock Index Fund	N/A	SVR2IS	_____
Large Company Value Stock Fund	N/A	ETCLCV	_____
Large Company Blend Stock Fund	N/A	FDFIDF	_____
Large Company Growth Stock Fund	N/A	FDGCOM	_____
Large Company Stock Index Fund	N/A	SV500	_____
High Yield Bond Fund	N/A	EVHYMA	_____
Diversified Bond Fund	N/A	MASDBD	_____
Bond Index Fund	N/A	SVPBMI	_____
Treas Inflation Protection TIPS Idx Fd	N/A	SVPTIP	_____
SMART Capital Preservation Fund	N/A	MELINC	_____

MUST INDICATE WHOLE PERCENTAGES = 100%

Last Name	First Name	M.I.	Social Security Number	98966-01 Number

Plan Beneficiary Designation

This designation is effective upon execution and delivery to Service Provider at the address below. I have the right to change the beneficiary. If any information is missing, additional information may be required prior to recording my beneficiary designation. If my primary and contingent beneficiaries predecease me or I fail to designate beneficiaries, amounts will be paid pursuant to the terms of the Plan Document or applicable law.

You may only designate one primary and one contingent beneficiary on this form. However, the number of primary or contingent beneficiaries you name is not limited. If you wish to designate more than one primary and/or contingent beneficiary, do not complete the section below. Instead, complete and forward the Beneficiary Designation form.

Primary Beneficiary

100.00%

% of Account Balance | Social Security Number | Primary Beneficiary Name | Date of Birth

( )
Phone Number *(Optional)*

Relationship *(Required - If Relationship is not provided, request will be rejected and sent back for clarification.)*

❑ Spouse ❑ Child ❑ Parent ❑ Grandchild ❑ Sibling ❑ My Estate ❑ A Trust ❑ Other ❑ Domestic Partner

Contingent Beneficiary

100.00%

% of Account Balance | Social Security Number | Contingent Beneficiary Name | Date of Birth

( )
Phone Number *(Optional)*

Relationship *(Required - If Relationship is not provided, request will be rejected and sent back for clarification.)*

❑ Spouse ❑ Child ❑ Parent ❑ Grandchild ❑ Sibling ❑ My Estate ❑ A Trust ❑ Other ❑ Domestic Partner

Participation Agreement

Withdrawal Restrictions - I understand that the Internal Revenue Code (the "Code") and/or my employer's Plan Document may impose restrictions on transfers and/or distributions. I understand that I must contact the Plan Administrator/Trustee to determine when and/or under what circumstances I am eligible to receive distributions or make transfers.

Investment Options - If I elect to direct my own investments, I understand that by signing and submitting this Participant Enrollment form for processing, I am requesting to have investment options established under the Plan as specified in the Investment Option Information section. I understand and agree that this account is subject to the terms of the Plan Document. I understand and acknowledge that all payments and account values, when based on the experience of the investment options, may not be guaranteed and may fluctuate, and, upon redemption, shares may be worth more or less than their original cost. I acknowledge that investment option information, including prospectuses, disclosure documents and Fund Profile sheets, have been made available to me and I understand the risks of investing.

I understand if I elect to have my account managed by Advised Assets Group, LLC ("AAG"), that my entire account, including any transfers or rollovers, will be professionally managed and I have not completed the Investment Option Information section. In the event investment option information is completed, my election to have my account professionally managed will override my investment option elections. Dollar cost averaging and asset allocation are not available if my account is professionally managed. I understand that the applicable fees will be deducted from my account. In order to enroll in the Managed Accounts Service, I understand that I must provide my Social Security number, date of birth, gender, marital status and annual income. If any of this information is not provided, I understand that I will not be enrolled in the Managed Accounts Service.

Compliance With Plan Document and/or the Code - I agree that my employer or Plan Administrator/Trustee may take any action that may be necessary to ensure that my participation in the Plan is in compliance with any applicable requirement of the Plan Document and/or the Code. I understand that the maximum annual limit on contributions is determined under the Plan Document and/or the Code. I understand that it is my responsibility to monitor my total annual contributions to ensure that I do not exceed the amount permitted. If I exceed the contribution limit, I assume sole liability for any tax, penalty, or costs that may be incurred.

Incomplete Forms - I understand that in the event my Participant Enrollment form is incomplete or is not received by Service Provider at the address below prior to the receipt of any deposits, I specifically consent to Service Provider retaining all monies received and allocating them to the default investment option selected by the Plan. If no default investment option is selected, funds will be returned to the payor as required by law. Once an account has been established on my behalf, I understand that I must call the Voice Response System or access the Web site in order to transfer monies from the default investment option. Also, I understand all contributions received after an account is established on my behalf will be applied to the investment options I have most recently selected.

Account Corrections - I understand that it is my obligation to review all confirmations and quarterly statements for discrepancies or errors. Corrections will be made only for errors which I communicate within 90 calendar days of the last calendar quarter. After this 90 days, account information shall be deemed accurate and acceptable to me. If I notify Service Provider of an error after this 90 days, the correction will only be processed from the date of notification forward and not on a retroactive basis.

Managed Accounts Service Fee - If you elect the Managed Accounts Service, a quarterly fee will be assessed. If you wish to opt-out in the future please call an Advised Assets Group, LLC ("AAG") Representative at your Plan's the Voice Response System number.

Last Name	First Name	M.I.	Social Security Number	98966-01 Number

Signature(s) and Consent

Participant Consent

I have completed, understand and agree to all pages of this Participant Enrollment form including the terms of the Managed Accounts Agreement. I understand that Service Provider is required to comply with the regulations and requirements of the Office of Foreign Assets Control, Department of the Treasury ("OFAC"). As a result, Service Provider cannot conduct business with persons in a blocked country or any person designated by OFAC as a specially designated national or blocked person. For more information, please access the OFAC Web site at:
http://www.treasury.gov/about/organizational-structure/offices/Pages/Office-of-Foreign-Assets-Control.aspx.
Deferral agreements must be entered into prior to the first day of the month that the deferral will be made.

Participant Signature **Date**

A handwritten signature is required on this form. An electronic signature will not be accepted and will result in a significant delay.

Participant forward to Service Provider at:
Great-West Retirement Services®
255 Bear Hill Road
Waltham, MA 02451
Phone #: 1-877-457-1900
Fax #: 1-781-890-2919
Web site: www.mass-smart.com