Enrollment Form

for group coverage – health and/or dental

BlueCross BlueShield of Kansas

Section 1 – Applicant Information

First Name ____ MI ____ Social Security Number ____-____-____ (____) ____-____ Home Phone Number

Last Name ____ Suffix ____ (____) ____-____ Cell Phone Number (____) ____-____ Work Phone Number

Gender ☐ Male ☐ Female ____/____/____ Date of Birth

Mailing Address (if different from residential address)

Residential Address

City

City

State ZIP Code +4

State ZIP Code +4 County

E-mail Address

Section 2 – Enrollment Information

Employer Name

Group Number/Category ____/____/____ Date of Full-Time Hire

Check one:

☐ I am a new employee enrolling at my first opportunity.

☐ I was part-time ____/____/____ Date of Part-Time Hire, am now full-time.

☐ I am a rehired employee.

☐ I am a variable hour employee* eligible as of

____/____/____.

My original date of hire was ____/____/____.

* For large groups only. See Plan Administrator.

Actively working ____ hours weekly for this employer.

☐ I am an existing employee enrolling due to:

☐ Employer's Open Enrollment ☐ Birth/Adoption
☐ Marriage ☐ Divorce
☐ Involuntary Loss of Coverage (explain)

☐ Other (give reason)

Official Date of Occurrence ____/____/____

Documentation of event may be required to complete enrollment. You will be notified if such documentation is required.

If you are currently enrolled in Blue Cross and Blue Shield of Kansas coverage, please provide your current ID number.

Member ID Number

If you don't know which benefit plan(s) your company offers, please see your Plan Administrator.

I want coverage for:	Health	Dental	Vision
Employee only	☐	☐	☐
Employee and spouse	☐	☐	☐
Employee and child(ren)	☐	☐	☐
Employee and family	☐	☐	☐

I want to participate in:

Flexible Spending Account (FSA) ☐Yes ☐No

Health Savings Account (HSA) ☐Yes ☐No

High Deductible Health Plan (HDHP) ☐Yes ☐No

Option ____

~~**Important – Tobacco Use (BlueCare policies only):**~~ Answer the following questions for yourself and each dependent (age 21 and over) – Have you used any tobacco products, including cigarettes, e-cigarettes, pipe tobacco, hookah, cigars, smokeless tobacco, etc., on average 4 or more times per week within the past 6 months, not including for religious or ceremonial use?

If yes, do you agree to participate in and complete our cessation program? (continue below) N/A

Applicant (Same as listed in Section 1):

Tobacco Use: ☐Yes ☐No Cessation Program: ☐Yes ☐No

Section 2A – Dependent Information (please use extra sheet to add additional dependents)

Relationship to applicant: ☐ Spouse

____ / ____ / ____
Date of Marriage

_____ ____
First Name MI

Gender ☐ Male ☐ Female

____ / ____ / ____
Date of Birth

_____ ____ _____
Last Name Suffix

____-____-____
Social Security Number

Type of coverage I am choosing: (check all that apply)
☐ Health ☐ Dental

Tobacco Use: ☐ Yes ☐ No
Cessation Program: ☐ Yes ☐ No

Relationship to applicant: ☐ Child ☐ Stepchild ☐ Legal Guardianship ☐ Legal Custody

_____ ____
First Name MI

Gender ☐ Male ☐ Female

____ / ____ / ____
Date of Birth

_____ ____ _____
Last Name Suffix

____-____-____
Social Security Number

Type of coverage I am choosing: (check all that apply)
☐ Health ☐ Dental

Tobacco Use: ☐ Yes ☐ No
Cessation Program: ☐ Yes ☐ No

Relationship to applicant: ☐ Child ☐ Stepchild ☐ Legal Guardianship ☐ Legal Custody

_____ ____
First Name MI

Gender ☐ Male ☐ Female

____ / ____ / ____
Date of Birth

_____ ____ _____
Last Name Suffix

____-____-____
Social Security Number

Type of coverage I am choosing: (check all that apply)
☐ Health ☐ Dental

Tobacco Use: ☐ Yes ☐ No
Cessation Program: ☐ Yes ☐ No

Section 3 – Other Health Coverage

Is anyone applying for this coverage enrolled in any other health/dental insurance (excluding Medicare, Medicaid or SRS)? ☐ Yes ☐ No

Do you or any of your listed dependents have Medicare Parts A and/or B? ☐ Yes ☐ No

Are you entitled to Medicare due to ESRD (permanent kidney failure)? ☐ Yes ☐ No

Name of family member with Medicare coverage:

_____ ____
First Name MI

_____ ____
Last Name Suffix

_____
Medicare ID Number

____ / ____ / ____
Part A Effective Date

____ / ____ / ____
Part B Effective Date

Section 4 – Authorization

By signing this authorization, I represent that the information I have stated is true to the best of my knowledge and belief and I understand that Blue Cross and Blue Shield of Kansas (BCBSKS), an independent licensee of the Blue Cross Blue Shield Association, will re-rate, terminate or rescind the contract if such information received at any time indicates the information provided in this enrollment process intentionally misrepresented a material fact or was fraudulent.

Unless you are enrolling in a Qualified Health Plan, this policy does not provide Exchange Certified pediatric dental or vision essential benefits pursuant to the Affordable Care Act and does not satisfy the "reasonable assurance" requirement.

Online Certificates Available

☐ **Yes, I would like to view my certificates online.**

_____
E-mail Address

☐ No, please send a paper copy to me.

Your signature required

_____
Applicant (Signature of parent/guardian if other than applicant)

____ / ____ / ____
Date Signed