

# The Hospital Indemnity Plan

ENROLLMENT FORM

For office use only		
Group No.	Rep. No.	Effective Date

Applicant's Name \_\_\_\_\_ Social Security No. \_\_\_\_\_

Address \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_  
Street

\_\_\_\_\_  
City State ZIP

Male  Female

Phone No.(\_\_\_\_) \_\_\_\_\_

1. Are you currently enrolled with Blue Cross and Blue Shield of Kansas?  Yes  No

If yes,  Individual  Group coverage

If group coverage, company name \_\_\_\_\_

2. This coverage is replacing my Blue Cross and Blue Shield of Kansas Hospital Confinement or Security Plan coverage.  Yes  No

If yes, please give your ID No. \_\_\_\_\_

3. I want to enroll in:

Individual (under age 65)  Individual/Spouse  Individual/Children

Individual (over age 65)  Individual/Spouse/Children

Name of Spouse and Dependent Children First MI. Last (if not the same)	Check Relationship	Date of Birth MM DD YY	Social Security No.
	<input type="checkbox"/> Spouse	/ /	
	<input type="checkbox"/> Daughter <input type="checkbox"/> Son	/ /	
	<input type="checkbox"/> Daughter <input type="checkbox"/> Son	/ /	
	<input type="checkbox"/> Daughter <input type="checkbox"/> Son	/ /	

▶ Signature of Applicant X \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_



An Independent Licensee of the Blue Cross and Blue Shield Association.

## Automatic Payment Authorization

If you are currently on our automatic payment program and we issue you a HIP contract, we will add the premium to that monthly payment unless you tell us otherwise. If you are not currently on the automatic payment option and would like to be, please complete and sign the authorization form below.

Financial Institution \_\_\_\_\_

Street \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

Account No. \_\_\_\_\_ Checking  Savings

▶ Signature of Applicant **X** \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

IMPORTANT: Remember to return a voided check or a deposit slip with this form to ensure accurate processing. You hereby authorize Blue Cross and Blue Shield of Kansas (BCBSKS) to charge to your account payment of the HIP premium. Should any payment entry be dishonored for any reason, or drawn after the depositor's authorization has been withdrawn, BCBSKS agrees that your financial institution shall be relieved of any liability. Your signature above gives BCBSKS the authority to automatically deduct payments for your HIP coverage.

## Proxy (Optional)

I hereby appoint the board of directors ("Board") of Blue Cross and Blue Shield of Kansas, Inc, ("Company") as my proxy to act on my behalf at all annual meetings of the policyholders of the Company. This appointment shall include such persons as the Board may designate by resolution to act on its behalf. This proxy gives the Board, or its designee, full power to vote for me on all matters that may be voted upon at any annual meeting. This proxy, unless revoked, shall remain in effect during my membership in the Company. I may revoke this proxy in writing by advising the Company of such at least five (5) days prior to any meeting. I may also revoke my proxy by attending and voting in person at any annual meeting.

▶ Signature of Applicant **X** \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

**Please mail your completed application to:**

Blue Cross and Blue Shield of Kansas  
Individual Sales Dept.  
PO Box 517  
Topeka, KS 66601-9834

or

Fax to (785) 290-0716