Income Verification Form

BlueCross BlueShield of Kansas*
www.bcbsks.com
ValueBlue℠

Section 1

Applicant Information:

Name _____ _____ _____
Last (Sr., Jr., etc.) First MI

Physical Address _____
Street

_____ _____ _____ _____
City State ZIP Code County

Mailing Address _____
if different from physical address Street

_____ _____ _____ _____
City State ZIP Code County

If we need additional information, we will try to contact you by phone. Which time is best to reach you? AM or PM (circle one)

Daytime Phone No. (_____) _____ Home Phone No. (_____) _____
Area Code Area Code

Section 2

Qualifications: Income verification is necessary to complete the process and determine eligibility. This income information will be reviewed annually. Below you will find the 2009 Federal Poverty Level Table. If household income is close to these guidelines, get an application and apply today.

You must:

- Live in the state of Kansas, except Johnson and Wyandotte counties.
- Complete the Income Verification Form.
- List all household members.*
- Sign and date the Income Verification Form.
- Provide the gross annual household income. This would include the most current federal income tax returns for all household income.
- If self-employed, provide your most current tax return, **including all schedules and attachments.**

*Household income refers to all income earned by the Insured(s) and any spouse or dependent children of the Insured(s) age 18 and over. Household income shall also include all income of any individual or individuals who claim an Insured as a dependent for tax purposes.

2009 Federal Poverty Level Percentages – Monthly

Household Size	200%
1	$ 1,805
2	$ 2,428
3	$ 3.052
4	$ 3,675
5	$ 4,298
6	$ 4,922
7	$ 5,545
8	$ 6,168
For each additional person, add	$623

Section 3

Please list everyone in your household, starting with yourself on the first line.

Full Name	Are you applying for this person? Yes	No	Social Security Number**	Relationship to you	Date of Birth	Gender

**Providing a Social Security number for everyone listed may help us to serve you better.

Section 4

Health Insurance: Tell us about anyone listed in Section 3 who is covered or who has been covered in the past 12 months by health insurance of any kind. Applies to initial enrollment only.

List the name or names of persons covered and the name of the health insurance carrier (i.e., Healthwave, BCBSKS, State Farm, etc.)	1. Name: Carrier:	1. Name: Carrier:	1. Name: Carrier:
	1. Name: Carrier:	1. Name: Carrier:	1. Name: Carrier:

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

Please continue on other side.→

Section 5

Tell us about your income: Does anyone receive the following types of income? ☐ Yes ☐ No

If yes, complete the chart below and attach proof of income to include the most current federal income tax returns and check stubs for all working adults (18 years of age and older). Self employment is addressed in Section 6. Please use an additional sheet of paper if you need more space.

- child support
- employment/tips
- rental income
- monthly income from family
- alimony
- veteran's benefits
- worker's compensation
- unemployment
- pensions
- military allotments
- Social Security/SSI
- student grants
- other (investment income, interest, etc.)

Name of Person Working or Receiving Income	Type of Income	Employer Name and Telephone Number (if applicable)	Amount Received Before Taxes/ Deductions	Amount of Tips or Commission	Hourly Wage and Hours Worked Per Week

Section 6

Self Employment: Please list anyone who is self employed and **attach a copy of their most current complete tax return.**

Name	Name and Type of Business	Hours Worked Per Week	Total Monthly Income Before Expenses are Deducted	Total Monthly Business Expenses

Section 7

Important Information to Certify Your Income Verification Form and Authorization to Release Information: Please read the following important statements and sign below to complete your Income Verification Form.

- I certify that I am requesting health coverage and that I must be a resident of the state of Kansas.
- I understand it is important to provide current income, address and household composition information.
- I understand any policy issued to me will be issued in reliance on the information I have provided on this Income Verification Form.
- I understand that Blue Cross and Blue Shield of Kansas (BCBSKS) will re-rate, terminate or rescind the contract for the following conditions: 1) if information received within two years after the date the contract becomes effective indicates information provided on this Income Verification Form was incorrect; 2) if such information received at any time indicates the information provided in this Income Verification Form was materially misstated or was fraudulent.
- I understand no representative of BCBSKS has the authority to waive any information required on this Income Verification Form; or to bind BCBSKS to provide coverage for me or any of my dependents or to waive, alter or change the provisions of the contract which may be issued.
- I understand that by signing this Income Verification Form, I authorize any former and/or current employer (if applicable), insurance company, or any other organization or person who has information or obtains information concerning me or any of my dependents covered by this form, to give it to BCBSKS.
- I understand that my signature (and my spouse's, if applicable) verify that I (we) have read all of the information on this form and certify that it is correct and accurate. I understand BCBSKS shall have no liability for payment of services until all of the following occur: a) the enrollment form has been received and approved; b) an official contract has been issued and delivered; and c) the full first premium has actually been paid to and accepted by BCBSKS.
- **I understand all coverage is subject to the income information provided on this form remaining unchanged to the effective date of coverage. If any change in income occurs before the effective date of coverage, I understand I must notify the BCBSKS Underwriting Department at 1-800-432-0216. (A photographic copy of this authorization shall be as valid as the original.)**
- I understand the questions on this form and I understand there are penalties for hiding information or giving false information.
- I certify under penalty of perjury that my answers are correct and complete to the best of my knowledge.

Your signature required _____ **Date** ____/____/____

Spouse's signature (if applicable) _____ **Date** ____/____/____