

Income Verification Form



www.bcbsks.com

Section 1

Applicant Information:

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

Residential Address _____
Street

City State ZIP Code County

Mailing Address _____
if different from residential 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 2011 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.**

2011 Federal Poverty Level Percentages - Monthly	
Household Size	200%
1	\$ 1,815
2	\$ 2,452
3	\$ 3,088
4	\$ 3,725
5	\$ 4,362
6	\$ 4,998
7	\$ 5,635
8	\$ 6,272
For each additional person, add \$637	

*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.

Section 3

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

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

**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:

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 for all working adults 18 years of age and older. 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.)

If no taxes were filed, please furnish at least one of the following:

- W-2's, if applicable, for the most current federal income tax year, for all working adults 18 year of age and older.
- 1099's, if applicable, for the most current federal income tax year, for all working adults 18 years of age and older.
- Paycheck stubs, if applicable, from all employers during the most current federal income tax year, for all working adults 18 years of age and older.
- If anyone listed on the income verification form was financially supported by another individual, please submit a letter from the individual supporting said individual(s).

Please use an additional sheet of paper if you need more space.

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

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

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 certify I have provided 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 intentionally misrepresented a material fact 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 represent that all statements made herein are complete and true to the best of my knowledge. I understand that failure to provide any material information or if I intentionally misrepresent any material fact, such omission or intentional misrepresentation may result in re-rating, termination or rescission of my health care coverage and/or criminal prosecution.

Your signature required

Date _____/_____/_____

Print Your Name _____

Enrollment Form

with health statement (for First Choice coverage)

For office use only		
Sys. Number	Rep. Number	Date
Business Name		

I understand that completing this form in **no way obligates me to purchase coverage**. I will complete the information below for each person requesting coverage. I understand all information is kept confidential.

Please answer all of the following questions for each person interested in coverage.

Applicant

Name _____ Male Female
Last First MI

Residential Address _____
Street

City County State ZIP Code + 4

Mailing Address _____
if different from residential address Street/P.O. Box

City State ZIP Code + 4

Home Phone (_____) _____ Work Phone (_____) _____
Area Code Area Code

Cell Phone (_____) _____ Fax (_____) _____
Area Code Area Code

Social Security No. _____ E-mail Address _____

Date of Birth ____/____/____ Height _____ Weight _____
MM DD YYYY

Married? Yes No Date of marriage ____/____/____
MM DD YYYY

I currently have Blue Cross and Blue Shield of Kansas (BCBSKS) coverage. Yes No _____
Member ID Number

I am replacing my current BCBSKS coverage with this policy. Yes No

I want to add a family member to my existing policy. Yes No

The type of coverage I am choosing is: (check all that apply) Health Insurance Dental Insurance

I want coverage for: (check one) Myself only* Myself and my spouse Myself and my child(ren) Myself and my family

* Note: Must be at least 19 years of age.

Spouse Name _____
Last First MI

Social Security No. _____

Date of Birth ____/____/____ Gender Male Female Height _____ Weight _____
MM DD YYYY

Dependent must be under age 26 and a dependent either naturally, through adoption, as a stepchild or you must have legal guardianship* or legal custody*. (*not eligible for life insurance.)

Dependent Name _____
Last First MI

Social Security No. _____ Relationship to Applicant Child Stepchild Legal guardian Legal custody

Date of Birth ____/____/____ Gender Male Female Height _____ Weight _____
MM DD YYYY

Dependent Name _____
Last First MI

Social Security No. _____ Relationship to Applicant Child Stepchild Legal guardian Legal custody

Date of Birth ____/____/____ Gender Male Female Height _____ Weight _____
MM DD YYYY



**BlueCross
BlueShield
of Kansas**



Section 1

Dependent Name _____
Last First MI

Social Security No. _____ Relationship to Applicant Child Stepchild Legal guardian Legal custody

Date of Birth ____/____/____ Gender Male Female Height _____ Weight _____
MM DD YYYY

Dependent Name _____
Last First MI

Social Security No. _____ Relationship to Applicant Child Stepchild Legal guardian Legal custody

Date of Birth ____/____/____ Gender Male Female Height _____ Weight _____
MM DD YYYY

Dependent Name _____
Last First MI

Social Security No. _____ Relationship to Applicant Child Stepchild Legal guardian Legal custody

Date of Birth ____/____/____ Gender Male Female Height _____ Weight _____
MM DD YYYY

Has anyone listed above gained entry to the U.S. through a VISA? If so, who and what type? _____

Section 2 asks questions about health conditions. Don't be overly concerned about answering "yes" to a question. A "yes" doesn't automatically disqualify you from coverage. Remember to mark "yes" *only if medical service for the listed condition has been received in the last 5 years*, then give details in Section 3. Please check the boxes "yes" or "no". For each answer marked "yes", circle the condition and explain in Section 3 below. The questions answered for individuals under age 19 will only be used for rating purposes.

yes **no** Please check the boxes "yes" or "no". For each answer marked "yes", circle the condition and explain in Section 3 below:

1. Do you or any dependent currently smoke? If yes, who? _____

2. Have you or any other person(s) to be insured been diagnosed or treated for any of the following in the past 5 years:

a. heart or circulatory problems?

b. high blood pressure? (If yes, **please provide average of last 3 readings** ____/____)

c. lungs or respiratory problems?

d. disorders of the kidneys or reproductive organs?

e. disorder of the liver, gallbladder, intestines, rectum, stomach or other vital organs?

f. diabetes or high blood sugar? If yes, **please provide A1C reading** _____

g. neurological disorder, stroke, physical incapacitation or seizures?
 If yes, **date of last seizure** _____

h. immune deficiency disorder or AIDS/AIDS-related complex?

i. cancer or malignancy?

j. blood, gland or skin problems?

k. arthritis, paralysis, disease or disorder of the muscles, bones or joints?

l. disorder of the esophagus, throat, nose or eyes (not to include eye glasses or contact lenses)?

m. alcoholism or other drug/substance dependency?

n. depression, anxiety, or any mental/nervous condition?

3. In the past five years have you or any person to be insured:

a. consulted a health care provider, received treatment at a hospital or other medical facility or been advised to have treatment for **any other condition not listed?**

b. used any narcotics or controlled substances, except as legally prescribed by a physician?

c. taken a prescription drug for a continuous 30-day or more time period? (include treatment dates below)

4. Are any of the persons listed pregnant?

5. Are you or any dependent disabled or aware of any condition that has prevented you or any dependent from receiving health, life or accident insurance in the past 5 years?

Explain conditions in detail for any “yes” responses in the previous section. Omitted information may cause delays. If additional space is needed, please attach a separate sheet.

Question no.	Person treated	Diagnosis or details about condition, treatment, medication name & dosage	Date diagnosed/ treated	Date physician last seen	Is further treatment recommended? (please explain)	Physician name, city and state
					<input type="checkbox"/> Yes <input type="checkbox"/> No	
					<input type="checkbox"/> Yes <input type="checkbox"/> No	
					<input type="checkbox"/> Yes <input type="checkbox"/> No	
					<input type="checkbox"/> Yes <input type="checkbox"/> No	
					<input type="checkbox"/> Yes <input type="checkbox"/> No	
					<input type="checkbox"/> Yes <input type="checkbox"/> No	
					<input type="checkbox"/> Yes <input type="checkbox"/> No	
					<input type="checkbox"/> Yes <input type="checkbox"/> No	

Section 3

Waiting Periods: You (and all family members) will have a 240-day waiting period from the effective date of coverage on the following conditions (whether or not the condition existed prior to the effective date of the policy):

1. Obstetrical services¹ — standard plan includes coverage on Individual/Spouse and Individual/Spouse/Children policies.
2. Operations for removal of tonsils and/or adenoids.
3. Treatment for tumors or growths.
4. Treatment for hernia.
5. Treatment for conditions of gallbladder, rectum and genito-urinary tract.

¹Obstetrical services on Individual and Individual/Children policies are available upon request at an additional premium. If purchased, obstetrical services are subject to the above 240-day waiting period.

When a condition subject to a waiting period is the primary diagnosis, the waiting period applies to all conditions treated during that hospital or medical care facility stay.

The waiting periods do not apply to a newborn child, if the child would otherwise be covered by the parent’s coverage.

Single Maternity Coverage: There is no single maternity coverage included in this policy unless you wish to purchase a single maternity rider separately at an additional premium.

Pre-Admission Certification: All admissions to hospitals and medical care facilities for inpatient care require prior authorization by Blue Cross and Blue Shield of Kansas, unless the admission is for a life- threatening condition or for obstetrical care. If no pre-admission request is made, you may be financially responsible for any medically unnecessary services provided.

Deductible & Coinsurance: Your deductible and coinsurance will start over again on April 1 of each year.

Section 4

Important Information

Please read the following important statements and **sign below to complete your enrollment form.**

Section 5

- I understand that Blue Cross and Blue Shield of Kansas, Inc. (BCBSKS) will re-rate, terminate or rescind the contract for the following conditions: 1) if the information received from future claims or supporting records within two years after the date the contract becomes effective indicates information provided on this enrollment form was incorrect; 2) if such information received at any time indicates the information provided in this enrollment form intentionally misrepresented a material fact or was fraudulent. **Rescinding only pertains to individual/non-group contracts and is not applicable to group contracts.**
- For Advance Insurance Company of Kansas (AICK), no misrepresentation made in obtaining or securing a policy of insurance on the life or lives of any person or persons, citizens of this state, shall be deemed material or render the policy void unless the matter misrepresented shall have actually contributed to the contingency or event on which the policy is to become due and payable. Any dependents obtained through legal guardianship or legal custody are not eligible for life insurance.
- I understand no representative of BCBSKS or AICK has the authority to waive any information required on this enrollment 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 my signature verifies that I have read all of the information on this form and represent that all statements made herein are complete and true to the best of my knowledge. I understand BCBSKS or AICK shall have no liability for payment of services until all of the following occur: 1) the enrollment form has been received and approved, 2) an official contract has been issued and delivered, and 3) the full first premium has actually been paid to and accepted by BCBSKS or AICK.
- **I understand all coverage is subject to the health of all applicants on this enrollment form remaining unchanged to the effective date of coverage. If any change in health 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.)**

Proxy

Section 6

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.

I accept I do not accept

Authorization for the Release of Protected Health Information:

Section 7

- I understand that by signing this enrollment form, I authorize the disclosure of all health information by any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility, other health care provider, insurance company, or any other organization or person who has provided payment, treatment, or services to me or on my behalf or to any of my dependents covered by this enrollment form or on their behalf, to BCBSKS or AICK.
- I understand that the information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and will no longer be protected by federal privacy regulations.
- I further understand that by signing this enrollment form, I authorize BCBSKS to disclose any and all health information they possess or obtain about me or about my dependents covered by this enrollment form to AICK for the purpose of determining initial or continuing eligibility for coverage and that BCBSKS conditions payment, enrollment, and eligibility of benefits on my authorizing such disclosures.
- This authorization is valid for a period no greater than 2 years. I understand that revocation of this authorization will not affect any action taken in reliance upon this authorization before the written revocation was received.

Applicant’s signature required

_____ Date ____/____/____

Print Your Name _____