Change Form

for group coverage

BlueCross BlueShield Kansas

Section 1 – Applicant Information (completion of this section is required) CLEAR DATA

First Name _____ MI _____ Gender ☐ Male ☐ Female Date of Birth _____ / _____ / _____

Last Name _____ Suffix _____ Social Security Number _____-_____-_____

Residential Address _____ Home Phone Number (_____) _____-_____ Cell Phone Number (_____) _____-_____

City _____ Email Address _____

State _____ ZIP Code _____ +4 _____ County _____ Employed by _____

Mailing Address (if different from residential address) _____ Work Phone Number (_____) _____-_____ Fax Number (_____) _____-_____

City _____ Group Number/Category _____

State _____ ZIP Code _____ +4 _____ County _____ Member ID Number _____

Section 2 – Enrollment Information

I want to enroll in: ☐ Health ☐ Dental ☐ Vision

Reason for change:

☐ Open Enrollment ☐ Birth/Adoption ☐ Marriage ☐ Divorce

☐ Involuntary Loss of Coverage (explain) _____

☐ Other (give reason) _____

Official Date of Qualifying Event _____ / _____ / _____

This is not the effective date. Documentation of event may be required to complete enrollment. You will be notified if such documentation is required.

Do you have separate dental coverage with Blue Cross or another carrier? ☐ Yes ☐ No

Section 2A – Adding Family Members to Coverage (please use extra sheet to add additional dependents)

Note: Complete all fields in section 2A for each dependent you wish to add.

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

First Name _____ MI _____ Gender ☐ Male ☐ Female Date of Birth _____ / _____ / _____

Last Name _____ Suffix _____ Social Security Number _____-_____-_____ Date of Marriage/Adoption _____ / _____ / _____

Type of health coverage for this dependent (check all that apply): ☐ Health ☐ Dental ☐ Vision

Do you have separate dental coverage with Blue Cross or another carrier? ☐ Yes ☐ No

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

First Name _____ MI _____ Gender ☐ Male ☐ Female Date of Birth _____ / _____ / _____

Last Name _____ Suffix _____ Social Security Number _____-_____-_____ Date of Marriage/Adoption _____ / _____ / _____

Type of health coverage for this dependent (check all that apply): ☐ Health ☐ Dental ☐ Vision

Do you have separate dental coverage with Blue Cross or another carrier? ☐ Yes ☐ No

Section 2A – Adding Family Members to Coverage (continued)

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

First Name _____ MI _____ Gender ☐ Male ☐ Female _____ / _____ / _____ Date of Birth

Last Name _____ Suffix _____ Social Security Number _____-_____-_____ _____ / _____ / _____ Date of Marriage/Adoption

Type of health coverage for this dependent (check all that apply): ☐ Health ☐ Dental ☐ Vision

Do you have separate dental coverage with Blue Cross or another carrier? ☐ Yes ☐ No

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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 3 – Removing Family Members from Coverage (please use extra sheet to add additional dependents)

Check one: (please list specific members you are removing below)

☐ Change to employee only ☐ Change to employee and spouse ☐ Change to employee and child(ren)

☐ Retain family and terminate coverage for: _____

Reason for change:

☐ Divorce ☐ Child reaching age limit ☐ Death ☐ Other (give reason): _____

_____ / _____ / _____
Official Date of Occurrence

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

First Name _____ MI _____ Gender ☐ Male ☐ Female _____ / _____ / _____ Date of Birth

Last Name _____ Suffix _____ Social Security Number _____-_____-_____

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

First Name _____ MI _____ Gender ☐ Male ☐ Female _____ / _____ / _____ Date of Birth

Last Name _____ Suffix _____ Social Security Number _____-_____-_____

Section 4 – Other Changes and Comments

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

To process the above changes, please sign and date:

Your signature required

_____ Applicant _____ / _____ / _____ Date Signed

_____ Plan Administrator Representative, Plan Sponsor Representative or Officer of the Company _____ / _____ / _____ Date Signed