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.

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

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

Section 2B – Other Coverage (please use extra sheet to add additional dependents with other coverage)

Is anyone applying for this coverage enrolled in any other health insurance? ☐ Yes ☐ No

_____ /_____ /_____
Other Coverage Effective Date

Is anyone applying for this coverage enrolled in any other dental insurance? ☐ Yes ☐ No

_____ /_____ /_____
Other Coverage Effective Date

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

_____ /_____ /_____
Medicare Part A Effective Date

_____ /_____ /_____
Medicare Part B Effective Date

Name of family member with Medicare or other coverage:

First Name _____ MI _____

Last Name _____ Suffix _____

Health Carrier Name _____

ID Number _____

Dental Carrier Name _____

ID Number _____

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 Designated Group Contact Date Signed