Change Form

for First Choice coverage

BlueCross BlueShield Kansas

For office use only

Sys. Number | Rep. Number | Date

Business Name

Section 1 – Applicant Information

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 Employer Name

State ZIP Code +4 County E-mail Address

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

City Group Number

State ZIP Code +4 Member ID Number

Section 2 – Change of Name or Address (Please check which address you would like to change.)

☐ Change name to:

First Name ____ MI

Last Name ____ Suffix

Change address: ☐ Residential ☐ Mailing ☐ Both

Street Address or P.O. Box

City

State ZIP Code +4

Section 3 – Add Family Members to Coverage (Add Health Profile for all individuals being added, if applicable.)

☐ Please add family members to my existing policy.

Official Date of Occurrence ____/____/____

Documentation of event may be required to complete enrollment. You will be notified if such documentation is required.

Reason for change:

☐ Birth/Adoption ☐ Marriage

☐ Divorce ☐ Involuntary Loss of Coverage

☐ Other ____

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 Adoption

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 Adoption

Please continue on the next page.

Section 3 – Add 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 Adoption

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 Adoption

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 Adoption

Section 4 – Combine Blue Cross Policies

First Name ____ MI ____ First Name ____ MI ____

Last Name ____ Suffix ____ Last Name ____ Suffix ____

Existing Blue Cross ID Number ____ Existing Blue Cross ID Number ____

Section 5 – Remove Family Members from Coverage

Check one: ☐ Change to myself only ☐ Change to myself/my spouse ☐ Change to myself/my child(ren)

☐ Retain family and terminate coverage for: ____________________

☐ If changing to sponsored coverage, see Section 6.

Give reason for change:

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

____/____/____ 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

Please continue on the next page.

Section 6 – Sponsored Coverage

Issue due to:

☐ Divorce ☐ Child reaching age limit

_____ /_____ /_____
Date of Occurrence

Issue: ☐ Single Contract

☐ Family Contract
(add Health Profile form for spouse and dependents)

First Name _____ MI _____

Last Name _____ Suffix _____

Street Address _____

City _____

State _____ ZIP Code _____ +4 _____ Social Security Number _____-_____-_____

Section 7 – 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. By signing this form, I attest that I will notify my dependent(s) of their insurance status change.

Your signature required

_____ _____ /_____ /_____
Applicant (Signature of parent/guardian if other than applicant) Date Signed

_____
Print Name

After completion of this form, you can mail it to:
Blue Cross and Blue Shield of Kansas
PO Box 239
Topeka, KS 66601

Or fax it to:
785-290-0770

bcbsks.com