Change Form

for BlueCare℠ non-group coverage

Note: This form is not intended for use by Marketplace enrollees.

BlueCross BlueShield of Kansas

For office use only:

Identifier

Section 1 – Applicant Information

CLEAR FORM

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

Last Name ____ Suffix ____-____-____ Social Security Number

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

City E-mail Address

State ZIP Code +4 County (____) ____-____ Work Phone Number

Mailing Address (if different from residential address) Member ID Number

City

State ZIP Code +4

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

☐ 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 ____

Important – Tobacco Use: Answer the following tobacco use question for each family member: Have any of your dependents used any tobacco products, including cigarettes, e-cigarettes, pipe tobacco, hookah, cigars, smokeless tobacco, etc., on average 4 or more times per week within the past 6 months, not including for religious or ceremonial use?

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

Tobacco use: ☐ 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 Adoption

Tobacco use: ☐ Yes ☐ No

Section 3 – Add Family Members to Coverage (continued)

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 4 – 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: _____

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

Section 5 – 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

Your signature required _____ _____ / _____ / _____
Spouse (If applying for coverage) Date Signed

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