Enrollment Form

for group coverage – health and/or dental

Rep Code: ________

Section 1 – Applicant Information

First Name ____ MI ____ Social Security Number ___-___-____ Home Phone Number (___) ___-____

Last Name ____ Suffix ____ Cell Phone Number (___) ___-____

Gender ☐ Male ☐ Female

Date of Birth ___/___/____

Mailing Address (if different from residential address) ____

Residential Address ____

City ____

City ____

State ____ ZIP Code ____ +4 ____

State ____ ZIP Code ____ +4 ____ County ____

Email Address ____

Section 2 – Enrollment Information

Employer Name ____

Group Number/Category ____

Date of Full-Time Hire ___/___/____

Check one:

☐ I am an employee enrolling at my first opportunity.

☐ I was part-time ___/___/____ (Date of Part-Time Hire), am now full-time.

☐ I am a variable hour employee,* eligible as of

___/___/____.

My original date of hire was ___/___/____.

* For large groups only. See Plan Administrator.

If you are currently enrolled in Blue Cross and Blue Shield of Kansas coverage, please provide your current ID number.

Member ID Number ____

☐ I am an existing employee enrolling due to:

☐ Employer's 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.

If you don't know which benefit plan(s) your company offers, please see your Plan Administrator.

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

Selected Health Plan ____

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

I want to participate in:

Flexible Spending Account (FSA) ☐ Yes ☐ No

Health Savings Account (HSA) ☐ Yes ☐ No

Section 2A – Dependent Information (use Section 5 for additional dependents, if needed)

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

Relationship to applicant: ☐ Spouse

_____ /_____ /________ Date of Marriage

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

Last Name ______ Suffix ____ _____-_____-________ Social Security Number

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

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

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

Last Name ______ Suffix ____ _____-_____-________ Social Security Number

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

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

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

Last Name ______ Suffix ____ _____-_____-________ Social Security Number

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

Section 3 – Other Health 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 4 – Authorization

By signing this authorization, I represent that the information I have stated is true to the best of my knowledge and belief and I understand that Blue Cross and Blue Shield of Kansas, an independent licensee of the Blue Cross Blue Shield Association, will re-rate or terminate the contract if such information received at any time indicates the information provided in this enrollment process intentionally misrepresented a material fact or was fraudulent.

Unless you are enrolling in a Qualified Health Plan, this policy does not provide Exchange Certified pediatric dental or vision essential benefits pursuant to the Affordable Care Act and does not satisfy the "reasonable assurance" requirement.

Your signature required

______ Applicant (Signature of parent/guardian if other than applicant)

_____ /_____ /________ Date Signed

Section 5 – Additional Dependents (Optional)

If you need to add more dependents than you could include in Section 2A, please use this page.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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