# Enrollment Form

for group coverage – health and/or dental

BlueCross BlueShield Kansas

## Section 1 – Applicant Information

CLEAR DATA

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 a new 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.

☐ I am an existing employee enrolling due to:

☐ Employer's Open Enrollment ☐ Birth/Adoption
☐ Marriage ☐ Divorce
☐ Involuntary Loss of Coverage (explain)

_____

☐ Other (give reason)

_____

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

Member ID Number _____

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

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
High Deductible Health Plan (HDHP) ☐ Yes ☐ No

Option _____

## **Section 2A** – Dependent Information (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 _____ /_____ /_____ 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
Do you have separate dental coverage with Blue Cross or another carrier? ☐ Yes ☐ No

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

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

## **Section 3** – Other Health Coverage

**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** – 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