Enrollment Form

for group coverage – health and/or dental

Rep Code: _____

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 an employee enrolling at my first opportunity.

☐ I was part-time _____ /_____ /_____, am now full-time.
Date of Part-Time Hire

☐ 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.

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.

Member ID Number _____

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

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

_____ _____ _____-_____-_____
Last Name Suffix Social Security Number

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

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

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

_____ _____ _____-_____-_____
Last Name Suffix Social Security Number

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

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

_____ _____ Gender ☐ Male ☐ Female _____ /_____ /_____
First Name MI 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 _____-_____-______

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