Group Secure 300 Cancer Plan and Group Secure Hospital Indemnity Plan Enrollment Form

for group coverage

This is a fixed indemnity policy that pays a set amount up to certain limits, regardless of the amount of medical bills. This policy is not a substitute for comprehensive health insurance.

Section 1 – Applicant Information

CLEAR DATA

First Name _____ MI _____

Last Name _____ Suffix _____

Residential Address _____

City _____

State _____ ZIP Code _____ +4 _____ County _____

Mailing Address (if different from residential address) _____

City _____

State _____ ZIP Code _____ +4 _____

Gender ☐ Male ☐ Female

Date of Birth _____ /_____ /_____

Social Security Number _____-_____-_____

Home Phone Number (_____) _____-_____

Cell Phone Number (_____) _____-_____

E-mail Address _____

Section 2 – Election Offerings

Employer Name _____

Group Number _____

Date of Full-Time Hire _____ /_____ /_____

Applying for:

☐ Group Secure 300 Cancer

☐ Group Secure HIP

☐ Both

Requested Effective Date _____ /_____ /_____

Please continue on the next page.

Section 3 – Dependent Information – Complete all fields below for each dependent being added.

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

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 4 – Authorization

Important information regarding your application:

- Any contract issued to you as a result of this application will be issued in reliance on information you provide on this form. If you intentionally fail to provide complete, accurate and correct information, Blue Cross and Blue Shield of Kansas (BCBSKS) may rescind the contract with all premiums refunded to you, less amounts paid for benefits under the contract.
- No representative of BCBSKS or any other entity has the authority to waive any of the information required on this form to bind BCBSKS to coverage of the applicants, or to waive, alter or amend any provision of any contract which may be issued to you.
- I understand coverage is subject to the health of all applicants on this application remaining unchanged to the effective date of coverage. If any change in health occurs before the effective date of coverage, I understand I must notify the BCBSKS underwriting department at 1-800-432-0216.

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 BCBSKS may re-rate or terminate contract if such information received at any time indicates the information provided in this enrollment process is incorrect.

Your signature required

________________ Applicant's Signature ____/____/____ Date Signed

________________ Print Name