

# Secure 300 Cancer Plan<sup>SM</sup> (Secure 300) Secure Hospital Indemnity Plan<sup>SM</sup> (S-HIP)

FOR OFFICE USE ONLY		
Reference No.	Rep No.	Effective Date

\_\_\_\_\_  
First Name M Last Name

\_\_\_\_\_  
Residential Address City

\_\_\_\_\_  
State\* ZIP Code (\_\_\_\_)\_\_\_\_-\_\_\_\_ Phone Number \_\_\_\_\_ Date of Birth (MM/DD/YYYY)

\_\_\_\_\_  
Social Security Number Gender  Male  Female

\*Coverage only available to Kansas residents

Do you and all family members enrolling have health insurance coverage as an individual or through an employer?  Yes  No

If no, please include person's name without coverage \_\_\_\_\_

Are you presently covered by Blue Cross and Blue Shield of Kansas?  Yes  No

If yes, please give your ID number \_\_\_\_\_

Group Number (if applicable) \_\_\_\_\_

I am applying for:  Secure 300  S-HIP  Both (double protection and good value)

Requested Effective Date: \_\_\_\_\_ Requested effective date is not valid more than 6 months from signature date. If left blank, your effective date will be the first of the month following receipt of this application.

**IF APPLYING FOR SECURE 300 COMPLETE THIS SECTION:**

Do you or any family member enrolling have cancer now, or have had any cancer in the past in any form?  Yes  No

If yes, include person's name \_\_\_\_\_

I want to enroll in:

- Individual (under age 65)  Ind/Spouse (under age 65)  Individual (over age 65)  
 Ind/Children (under age 65)  Ind/Spouse/Children (under age 65)

SPOUSE FULL NAME	<input type="checkbox"/> Male <input type="checkbox"/> Female	DATE OF BIRTH (MM/DD/YYYY)	SOCIAL SECURITY NO.
MARRIAGE DATE (MM/DD/YYYY)			
LIST DEPENDENT CHILDREN (If Applying) First Middle Last (If Not The Same)	CHECK <input checked="" type="checkbox"/> RELATIONSHIP	DATE OF BIRTH (MM/DD/YYYY)	SOCIAL SECURITY NO.
	<input type="checkbox"/> Daughter <input type="checkbox"/> Son		
	<input type="checkbox"/> Daughter <input type="checkbox"/> Son		
	<input type="checkbox"/> Daughter <input type="checkbox"/> Son		

## Please read and sign below:

### Important information to represent your application

- » I hereby authorize any licensed physician, practitioner, hospital, clinic, or other medical facility, insurance company, or any other organization, association or person who has or obtains information or knowledge of any person covered by this application, or of our health to give it to Blue Cross and Blue Shield of Kansas (BCBSKS). A photographic copy of this authorization should be as valid as the original. Your authorization for medical release is only valid for a period up to, but not extending beyond, 24 months. (Applicable to Secure 300 applicants ONLY.)
- » 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 or unintentionally fail to provide complete, accurate and correct information, the contract shall be rescinded 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.

**Your signature required**

Signature of Applicant

Date

## Important notice regarding Secure 300 and S-HIP coverage:

This is a supplement to health insurance and is not a substitute for major medical coverage. Lack of major medical coverage (or other minimum essential coverage) may result in an additional payment with your taxes.

### Proxy

I hereby appoint the board of directors ("Board") of Blue Cross and Blue Shield of Kansas, Inc., ("Company") as my proxy to act on my behalf at all annual meetings of the policyholders of the Company. This appointment shall include such persons as the Board may designate by resolution to act on its behalf. This proxy gives the Board, or its designee, full power to vote for me on all matters that may be voted upon at any annual meeting. This proxy, unless revoked, shall remain in effect during my membership in the Company. I may revoke this proxy in writing by advising the Company of such at least ten (10) days prior to any meeting. I may also revoke my proxy by attending and voting in person at any annual meeting.

Yes  No

**Your signature required**

Signature of Applicant

Date



BlueCross BlueShield

**Kansas**

[bcbsks.com](http://bcbsks.com)

An independent licensee of the Blue Cross Blue Shield Association.