Enrollment Form

for group coverage – health and/or dental

BlueCross BlueShield of Kansas

BlueCross BlueShield Kansas Solutions

Section 1 – Applicant Information

CLEAR DATA

First Name ____ MI ____ Social Security Number ____ Home Phone Number ____

Last Name ____ Suffix ____ Cell Phone Number ____ Work 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 ____

E-mail Address ____

Section 2 – Enrollment Information

NCKSEC #636 Employer Name

96448 Group Number

Date of Full-Time Hire ____

Check one:

☐ I am a new employee enrolling at my first opportunity.

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

☐ I am a rehired employee.

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

My original date of hire was ____ ____ ____.

*For large groups only. See Plan Administrator.

Actively working ____ hours weekly for this employer.

☐ I am an existing employee enrolling due to:

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

____

Official Date of Occurrence ____ ____ ____

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

____
Member ID Number

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

I want coverage for:	**Health**	**Dental**	**Vision**
Employee only	☐	☐	☐
Employee and spouse	☐	☐	☐
Employee and child(ren)	☐	☐	☐
Employee and family	☐	☐	☐

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 ____

Important – Tobacco Use (BlueCare policies only): Answer the following questions for yourself and each dependent (age 21 and over) – Have you used any tobacco products, including cigarettes, e-cigarettes, pipe tobacco, hookah, cigars, smokeless tobacco, etc., on average 4 or more times per week within the past 6 months, not including for religious or ceremonial use?

If yes, do you agree to participate in and complete our cessation program? (continue below)

Applicant (Same as listed in Section 1):

Tobacco Use: ☐ Yes ☐ No Cessation Program: ☐ Yes ☐ No

Section 2A – Dependent Information

Relationship to applicant: ☐ Spouse

_____ _____ _____
Date of Marriage

_____ _____
First Name MI

Gender ☐ Male ☐ Female

_____ _____ _____
Date of Birth

_____ _____
Last Name Suffix

_____ _____ _____
Social Security Number

Type of coverage I am choosing: (check all that apply)
☐ Health ☐ Dental

Tobacco Use: ☐ Yes ☐ No
Cessation Program: ☐ Yes ☐ No

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 coverage I am choosing: (check all that apply)
☐ Health ☐ Dental

Tobacco Use: ☐ Yes ☐ No
Cessation Program: ☐ Yes ☐ No

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 coverage I am choosing: (check all that apply)
☐ Health ☐ Dental

Tobacco Use: ☐ Yes ☐ No
Cessation Program: ☐ Yes ☐ No

Section 3 – Medicare / Other Party Liability

Do you or any of your listed dependents have Medicare Parts A and/or B? ☐ Yes ☐ No

If yes, provide name of family member with coverage:

_____ _____
First Name MI

_____
Last Name

_____
Medicare Number

_____ _____ _____
Part A Effective Date

_____ _____ _____
Part B Effective Date

Are you entitled to Medicare due to ESRD (permanent kidney failure)? ☐ Yes ☐ No

Is anyone applying for this coverage entitled to benefits for any other group insurance (excluding Medicare, SRS, Medicaid) for surgical, medical or dental expenses? ☐ Yes ☐ No

If yes, please provide current ID number:

_____
Current ID Number

Coverage is: ☐ Health only ☐ Dental Only ☐ Health and Dental

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 (BCBSKS) or BlueCross BlueShield Kansas Solutions (Solutions), independent licensees of the Blue Cross Blue Shield Association, will re-rate, terminate or rescind 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.

Online Certificates Available

☐ **Yes, I would like view my certificates online.**

_____
E-mail Address

☐ No, please send a paper copy to me.

Your signature required

_____ _____ _____
Applicant Date Signed