Enrollment Form

For group coverage – health and/or dental

www.bcbsks.com

Section 1

Name ______________________ Last (Sr., Jr., etc.) First MI

Date of Birth __________ MM DD YYYY

Residential Address ______________________ Street

______________________ City State ZIP Code + 4

Social Security No. __________

Gender ☐ Male ☐ Female

Mailing Address ______________________ Street
If different from residential address

______________________ City State ZIP Code + 4

Home Phone __________ Area Code

Work Phone __________ Area Code

Cell Phone __________ Area Code

Married? ☐ Yes ☐ No Date of Marriage __________ MM DD YYYY

Employed by ______________________

Group No. __________

Actively working ______ hrs weekly for this employer

Date of Full-Time Hire __________ MM DD YYYY

If you are currently enrolled in Blue Cross and Blue Shield of Kansas coverage, you are eligible to receive credit towards pre-existing waiting periods. Please provide current ID No. __________

Check one:

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

☐ I am an existing employee enrolling during my employer's annual open enrollment period.

☐ I am an existing employee enrolling due to a qualifying event such as, Birth/Adoption, Marriage, Divorce or Involuntary Loss of Coverage.

Reason: ______________________ Date of event: __________ MM DD YYYY

Section 2

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

Participating in: **Flexible Spending Account (FSA)** ☐ Yes ☐ No

Health Savings Account (HSA) ☐ Yes ☐ No

If more than one health option offered by group: (check one)

Triple Option ☐ Option 1 ☐ Option 2 ☐ Option 3

High Deductible Health Plan (HDHP) ☐ Yes ☐ No

Listed below are family members, including myself and my spouse, who are to be enrolled. (List last name if different.)
If your plan is grandfathered, adult dependents eligible through another employer group are not eligible for coverage through this plan.

Last	First	M.I.	Relationship To Employee	Date of Birth MM / DD / YY	Social Security No.	Gender	Full Time Student
Applicant			*Please use key for relationship:* **1** – Spouse **2** – Child **3** – Stepchild **4** – Legal guardian **5** – Legal custody				
							☐ Yes ☐ No
							☐ Yes ☐ No
							☐ Yes ☐ No
							☐ Yes ☐ No

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

Name of family member with coverage: ______________________ Last First M.I.

Medicare No. __________ Effective date Part A __________ Effective date Part B __________

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

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

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

I represent that all statements made herein are complete and true to the best of my knowledge. I understand that if I fail to provide any material information or if I intentionally misrepresent any material fact, such omission or intentional misrepresentation may result in the re-rating, termination or rescission of my health care coverage and/or criminal prosecution.

Your signature required ______________________ **Date** __________

An Independent Licensee of the Blue Cross and Blue Shield Association.