

Enrollment Form

For group coverage – health only



PremierBlue

www.bcbks.com

INSTRUCTIONS: Please PRINT in CAPITAL letters using **black ink** only.

Name _____
Last (Str., Jr., etc.) First MI

Date of Birth _____
MM DD YYYY

Address _____
Street

Social Security No. _____

City _____ State _____ ZIP Code _____

Gender Male Female Married? Yes No

Home Phone _____ Work Phone _____
Area Code Area Code

Date of Marriage _____
MM DD YYYY

Employed by _____ Group No. _____

Actively working _____ hrs weekly for this employer

Date of Hire _____
MM DD YYYY

Reason for change in employment: part time to full time temporary to permanent rehire/recall other (specify)

Date this occurred _____
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 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

I want coverage for:

Health	Dental
Employee only <input type="checkbox"/>	<input type="checkbox"/>
Employee and spouse <input type="checkbox"/>	<input type="checkbox"/>
Employee and child(ren) <input type="checkbox"/>	<input type="checkbox"/>
Employee and family <input type="checkbox"/>	<input type="checkbox"/>

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 applying for Premier Blue or Blue Select, the first and last name of your primary care physician is required.

Last	First	M.I.	Relationship To Employee	Date of Birth MM / DD / YY	Social Security No.	Gender	Full Time Student	Primary Care Physician
Applicant			<i>Please use key for relationship: 1 – Spouse 2 – Child 3 – Stepchild 4 – Other (specify)</i>				List Name and City	
							<input type="checkbox"/> Yes <input type="checkbox"/> No	
							<input type="checkbox"/> Yes <input type="checkbox"/> No	
							<input type="checkbox"/> Yes <input type="checkbox"/> No	
							<input type="checkbox"/> Yes <input type="checkbox"/> No	
							<input type="checkbox"/> Yes <input type="checkbox"/> 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

Your signature required

Date

Section 1

Section 2