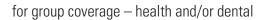
Enrollment Form





Section 1 – Applicant Information	
	()
First Name MI	Social Security Number Home Phone Number
Last Name Suffix	()Cell Phone Number
Gender \square Male \square Female ${Date ext{ of Birth}}$ //	Mailing Address (if different from residential address)
Residential Address	City
City	State ZIP Code +4
State ZIP Code +4 County	Email Address
Section 2 – Enrollment Information	
Employer Name	Group Number/Category Date of Full-Time Hire
Check one:	
\square I am an employee enrolling at my first opportunity.	\square I am an existing employee enrolling due to:
\square I was part-time $\frac{1}{\text{Date of Part-Time Hire}}$, am now full-time.	☐ Employer's Open Enrollment☐ Birth/Adoption☐ Divorce
\square I am a variable hour employee, eligible as of	☐ Involuntary Loss of Coverage (explain)
/	☐ Other (give reason)
My original date of hire was/	_ other (give reason)
*For large groups only. See Plan Administrator.	
If you are currently enrolled in Blue Cross and Blue	Official Date of Qualifying Event//
Shield of Kansas coverage, please provide your current ID number.	This is not the effective date. Documentation of event may be required to complete enrollment. You will be notified if such documentation is required.
Member ID Number	
If you don't know which benefit plan(s) your company offe	rs, please see your Plan Administrator.
I want to enroll in: ☐ Health ☐ Dental ☐ Vision	I want to participate in:
Selected Health Plan	Flexible Spending Account (FSA)
Do you have separate dental coverage with Blue Cross or another carrier? ☐ Yes ☐ No	Health Savings Account (HSA) ☐ Yes ☐ No

Section 2A – Dependent Information (use Sectio	n 5 for add	ditional dependents, if needed)	
Note: Complete all fields in section 2A for each	dependen	t you wish to add.	
Relationship to applicant: Spouse		/ Date of Marriage	
First Name	MI	Gender ☐ Male ☐ Female ☐ Date of Birth	
Last Name	Suffix	Social Security Number	
Type of health coverage for this dependent (che			
Do you have separate dental coverage with Blue			
Relationship to applicant: Child Stepchile	d 🗆 Le	gal Guardianship 🗆 Legal Custody	
First Name		Gender ☐ Male ☐ Female ☐ Interpreted Female ☐ Inte	
Last Name	Suffix	Social Security Number	
Type of health coverage for this dependent (chec Do you have separate dental coverage with Blue		• • •	
Relationship to applicant: Child Stepchile	d 🗆 Le	gal Guardianship 🗌 Legal Custody	
First Name		Gender \square Male \square Female ${Date \text{ of Birth}}$	
Last Name	Suffix	Social Security Number	
Type of health coverage for this dependent (che		,	
Do you have separate dental coverage with Blue Section 3 – Other Health Coverage Is anyone applying for this coverage enrolled	in any	another carrier?	
other health/dental insurance (excluding Med Medicaid or SRS)? ☐ Yes	dicare, □ No	First Name	MI
Do you or any of your listed dependents have M Parts A and/or B? ☐ Yes	ledicare No	Last Name	Suffix
Are you entitled to Medicare due to ESRD (pern	nanent	Medicare ID Number	
kidney failure)? ☐ Yes	□No	Part A Effective Date Part B Effective Date	
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, an independent licensee of the Blue Cross Blue Shield Association, will re-rate or terminate 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.	
		Unless you are enrolling in a Qualified Health Plan, this policy does not provide Exchange Certified pediatric dental or vision essential benefits pursuar to the Affordable Care Act and does not satisfy the "reasonable assurance" requirement.	
Your signature required		/	
Applicant (Signature of parent/gua	rdian if other	than applicant) Date Signed	

Page 2 bcbsks.com

Section 5 – Additional Dependents (Optional)	
If you need to add more dependents than you cou	ıld include in Section 2A, please use this page.
Relationship to applicant: Child Stepchild	☐ Legal Guardianship ☐ Legal Custody
First Name	Gender Male Female Date of Birth
Last Name	Suffix Social Security Number
Type of health coverage for this dependent (check Do you have separate dental coverage with Blue C	
Relationship to applicant: Child Stepchild	☐ Legal Guardianship ☐ Legal Custody
First Name	Gender Male Female Date of Birth
Last Name	Suffix Social Security Number
Type of health coverage for this dependent (check Do you have separate dental coverage with Blue C	• • •
Relationship to applicant: Child Stepchild	☐ Legal Guardianship ☐ Legal Custody
First Name	Gender Male Female//
Last Name	Suffix Social Security Number
Type of health coverage for this dependent (check Do you have separate dental coverage with Blue C	all that apply): ☐ Health ☐ Dental ☐ Vision
Relationship to applicant: Child Stepchild	☐ Legal Guardianship ☐ Legal Custody
First Name	Gender Male Female Date of Birth
Last Name	Suffix Social Security Number
Type of health coverage for this dependent (check Do you have separate dental coverage with Blue C	• • •
Relationship to applicant: Child Stepchild	☐ Legal Guardianship ☐ Legal Custody
First Name	Gender Male Female Date of Birth
Last Name	Suffix Social Security Number
Type of health coverage for this dependent (check Do you have separate dental coverage with Blue C	• • •
Relationship to applicant: Child Stepchild	☐ Legal Guardianship ☐ Legal Custody
First Name	Gender Male Female//
Last Name	Suffix Social Security Number
Type of health coverage for this dependent (check Do you have separate dental coverage with Blue C	all that apply): ☐ Health ☐ Dental ☐ Vision