Enrollment Form

for group coverage – health and/or dental

BlueCross BlueShield Kansas

Section 1 – Applicant Information

CLEAR DATA

First Name _____ MI _____

Last Name _____ Suffix _____

Gender ☐ Male ☐ Female

_____ /_____ /_____
Date of Birth

Residential Address _____

City _____

State _____ ZIP Code _____ +4 _____

County _____

_____-_____-_____
Social Security Number

(_____) _____-_____
Cell Phone Number

(_____) _____-_____
Home Phone Number

(_____) _____-_____
Work Phone Number

Mailing Address (if different from residential address) _____

City _____

State _____ ZIP Code _____ +4 _____

E-mail Address _____

Section 2 – Enrollment Information

Employer Name _____

96189
Group Number/Category

_____ /_____ /_____
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 variable hour employee,* eligible as of

_____ /_____ /_____.

My original date of hire was _____ /_____ /_____.

* For large groups only. See Plan Administrator.

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

Member ID Number _____

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)

_____

☐ Other (give reason)

_____

Official Date of Occurrence _____ /_____ /_____

Documentation of event may be required to complete enrollment. You will be notified if such documentation is required.

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 (please use extra sheet to add additional dependents)

Relationship to applicant: ☐ Spouse

_____ /_____ /_____
Date of Marriage

_____ _____ Gender ☐ Male ☐ Female _____ /_____ /_____
First Name MI 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

_____ _____ Gender ☐ Male ☐ Female _____ /_____ /_____
First Name MI 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

_____ _____ Gender ☐ Male ☐ Female _____ /_____ /_____
First Name MI 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 – Other Health Coverage

Is anyone applying for this coverage enrolled in any other health/dental insurance (excluding Medicare, Medicaid or SRS)? ☐ Yes ☐ No

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

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

Name of family member with Medicare coverage:

_____ _____
First Name MI

_____ _____
Last Name Suffix

_____
Medicare ID Number

_____ /_____ /_____
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 (BCBSKS), 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 pursuant to the Affordable Care Act and does not satisfy the "reasonable assurance" requirement.

Your signature required

_____ _____ /_____ /_____
Applicant (Signature of parent/guardian if other than applicant) Date Signed

This information is being furnished in compliance with applicable federal regulations.

This Notice has important information. This notice has important information about your application or coverage through Blue Cross and Blue Shield of Kansas. Look for key dates in this notice. You may need to take action by certain deadlines to keep your health coverage or help with costs. You have the right to get this information and help in your language at no cost. Please call 1-800-432-3990.

Discrimination is against the law.

Blue Cross and Blue Shield of Kansas (BCBSKS) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. BCBSKS does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Blue Cross and Blue Shield of Kansas:
- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact Holly Graves.

If you believe that BCBSKS has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Holly Graves, Director, Individual Sales and Customer Service, 1133 S.W. Topeka Blvd., Topeka, KS 66629-0001,
1-800-432-3990, TTY: 1-800-766-3777, Fax: 785-290-0711, CSC@bcbsks.com.

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Holly Graves is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Para obtener asistencia en español, llame al servicio de atención al cliente al número que aparece en su tarjeta de identificación.

請撥打您 ID 卡上的客服號碼以尋求中文協助。

Gọi số dịch vụ khách hàng trên thẻ ID của quý vị để được hỗ trợ bằng Tiếng Việt.

한국어로 도움을 받고 싶으시면 ID 카드에 있는 고객 서비스 전화번호로 문의해 주십시오.

Para sa tulong sa Tagalog, tumawag sa numero ng serbisyo sa customer na nasa inyong ID card.

Обратитесь по номеру телефона обслуживания клиентов, указанному на Вашей идентификационной карточке, для помощи на русском языке.

اتصل برقم خدمة العملاء الموجود على بطاقة هُويتك للحصول على المساعدة باللغة العربية.

Rele nimewo sèvis kliyantèl ki nan kat ID ou pou jwenn èd nan Kreyòl Ayisyen.

Pour une assistance en français du Canada, composez le numéro de téléphone du service à la clientèle figurant sur votre carte d'identification.

Ligue para o número de telefone de atendimento ao cliente exibido no seu cartão de identificação para obter ajuda em português.

Aby uzyskać pomoc w języku polskim, należy zadzwonić do działu obsługi klienta pod numer podany na identyfikatorze.

日本語でのサポートは、ID カードに記載のカスタマーサービス番号までお電話でお問い合わせください。

Per assistenza in italiano chiamate il numero del servizio clienti riportato nella vostra scheda identificativa.

Rufen Sie den Kundendienst unter der Nummer auf Ihrer ID-Karte an, um Hilfestellung in deutscher Sprache zu erhalten.

برای دریافت راهنمایی به زبان فارسی ، با شماره خدمات مشتری که بر روی کارت شناسایی شما درج شده است تماسبگیرید..