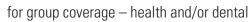
Enrollment Form





Section 1 – Applicant Info	ormation					
First Name			MI	() e Phone Numb	er
				() ()	
Last Name		,	Suffix	Cell Phone Number Work	Phone Number	er
Gender ☐ Male ☐ Fer	male <u> </u>	te of Birth	/	Mailing Address (if different from residential address)		
Residential Address				City		
City				State ZIP Code +4		
State ZIP Code +4		ounty		E-mail Address		
Section 2 – Enrollment In	formation					
					//_ of Full-Time Hi	
Employer Name				7 7		
Check one:			Actively working hours weekly for	or this emp	loyer.	
☐ I am a new employee enrolling at my first opportunity.			☐ I am an existing employee enrolling due to:			
\square I was part-time ${\square}$ Jate of Pal	rt-Time Hire	, am now	full-time.	☐ Employer's Open Enrollment☐ Marriage	Birth/Adop Divorce	otion
☐ I am a variable hour en	nployee* el	igible as of		\square Involuntary Loss of Coverage (ex	plain)	
/						
My original date of hire		1 1		☐ Other (give reason)		
*For large groups only. See Pla						
			N 01: 1	Official Date of Occurrence	/ /	
If you are currently enrolled of Kansas coverage, pleas					complete enroll	
Member ID Number						
If you don't know which b	enefit plan	s) your con	npany offe	rs, please see your Plan Administrator.		
I want coverage for:	Health	Dental	Vision	I want to participate in:		
Employee only				Flexible Spending Account (FSA)	□Yes	□No
Employee and spouse				Health Savings Account (HSA)	□Yes	
Employee and child(ren)				High Deductible Health Plan (HDHP)	□Yes	□No
Employee and family				Option		
-	-	_		llowing questions for yourself and each depende	-	
Have you used any tobacco pro 4 or more times per week within			-	, pipe tobacco, hookah, cigars, smokeless tobacc eligious or ceremonial use?	o, etc., on ave	erage
If yes, do you agree to particip	ate in and cor	nplete our ces	ssation progr	ram? (continue below)		
Applicant (Same as liste	ed in Section	on 1):				
Tobacco Use: ☐Yes ☐	No			Cessation Program: ☐ Yes ☐ No		

Section 2A – Dependent Information (please use ex	xtra she	et to add additional dependents)		
Relationship to applicant: Spouse		// Date of Marriage / Gender \square Male \square Female//		
First Name	MI	Date of Birth		
Last Name	Suffix	Social Security Number		
Type of coverage I am choosing: (check all that app Health Dental	oly)	Tobacco Use: ☐ Yes ☐ No Cessation Program: ☐ Yes ☐ No		
Relationship to applicant: Child Stepchild	☐ Leç	gal 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 app ☐ Health ☐ Dental	oly)	Tobacco Use: ☐ Yes ☐ No Cessation Program: ☐ Yes ☐ No		
Relationship to applicant: Child Stepchild	☐ Leç	gal Guardianship 🗌 Legal Custody		
First Name	MI	Gender \square Male \square Female ${Date ext{ of Birth}} / $		
Last Name	Suffix	Social Security Number		
Type of coverage I am choosing: (check all that app ☐ Health ☐ Dental	oly)	Tobacco Use: ☐ Yes ☐ No Cessation Program: ☐ Yes ☐ No		
Section 3 – Other Health Coverage				
Is anyone applying for this coverage enrolled in other health/dental insurance (excluding Medic	•	Name of family member with Medicare coverage:		
Medicaid or SRS)? □ Yes	□No	First Name	MI	
Do you or any of your listed dependents have Med Parts A and/or B? ☐ Yes	dicare □ No	Last Name	Suffi	
Are you entitled to Medicare due to ESRD (perman		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 is true to the best of my knowledge and belief and I understand that Blue Cross and Blue Shield of Kansas (BCBSKS), an independent lice of the Blue Cross Blue Shield Association, will re-rate or terminate t contract if such information received at any time indicates the information provided in this enrollment process intentionally misrepresented a magnitude for 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/guardia)	n if other	than applicant) — — — — — — — — — — — — — — — — — — —		