# Enrollment Form

for group coverage – health and/or dental

## Section 1 – Applicant Information

First Name ______ MI ______ Social Security Number ____-____-____ Home Phone Number (____) ____-____

Last Name ______ Suffix ______ Cell Phone Number (____) ____-____ Work Phone Number (____) ____-____

Gender ☐ Male ☐ Female

Date of Birth ____ / ____ / ______

Mailing Address (if different from residential address) ______

Residential Address ______

City ______

City ______

State ______ ZIP Code ______ +4 ______

State ______ ZIP Code ______ +4 ______ County ______

E-mail Address ______

## Section 2 – Enrollment Information

Employer Name ______

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


An independent licensee of the Blue Cross Blue Shield Association.

## Section 2A – Dependent Information (please use extra sheet to add additional dependents)

Relationship to applicant: ☐ Spouse

_____ /_____ /_______
Date of Marriage

First Name ______ MI ____

Gender ☐ Male ☐ Female

_____ /_____ /_______
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

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Relationship to applicant: ☐ Child ☐ Stepchild ☐ Legal 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 apply)
☐ Health ☐ Dental

Tobacco Use: ☐ Yes ☐ No
Cessation Program: ☐ Yes ☐ No

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Relationship to applicant: ☐ Child ☐ Stepchild ☐ Legal 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 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