Enrollment Form

Clear data

For group coverage – health and/or dental

BlueCross BlueShield of Kansas
www.bcbsks.com

Section 1

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

Name _____ (Last (Sr., 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 _____ (Area Code) Work Phone _____ (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)

Section 2

I want coverage for:	**Health**	**Dental**
Employee only	☐	☐
Employee and spouse	☐	☐
Employee and child(ren)	☐	☐
Employee and family	☐	☐

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.)

Last / First / M.I.	Relationship To Employee	Date of Birth MM / DD / YY	Social Security No.	Gender	Full Time Student
Applicant	*Please use key for relationship:* **1** – Spouse **2** – Child **3** – Stepchild **4** – Other (specify)				
					☐ Yes ☐ No
					☐ Yes ☐ No
					☐ Yes ☐ No
					☐ Yes ☐ No
					☐ Yes ☐ 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** _____