

Enrollment Form

For group coverage – health and/or dental



Section 1

Name _____
Last (Sr., Jr., etc.) First MI

Date of Birth _____
MM DD YYYY

Residential Address _____
Street

Social Security No. _____

City _____ State _____ ZIP Code + 4 _____

Gender Male Female

Mailing Address _____
If different from residential address Street

Home Phone _____
Area Code

City _____ State _____ ZIP Code + 4 _____

Work Phone _____
Area Code

Married? Yes No Date of Marriage _____
MM DD YYYY

Cell Phone _____
Area Code

Employed by _____

Group No. _____

Actively working _____ hrs weekly for this employer

Date of Full-Time Hire _____
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 a rehired employee.
 I am an existing employee enrolling due to: Employer's Open Enrollment Birth/Adoption Marriage Divorce
 Involuntary Loss of Coverage (explain) _____

Date of event: _____
MM DD YYYY

- I want coverage for:**
- | | | |
|-------------------------|--------------------------|--------------------------|
| Employee only | <input type="checkbox"/> | <input type="checkbox"/> |
| Employee and spouse | <input type="checkbox"/> | <input type="checkbox"/> |
| Employee and child(ren) | <input type="checkbox"/> | <input type="checkbox"/> |
| Employee and family | <input type="checkbox"/> | <input type="checkbox"/> |

- 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.)
 If your plan is grandfathered, adult dependents eligible through another employer group are not eligible for coverage through this plan.

Section 2

Last	First	M.I.	Relationship To Employee	Date of Birth MM / DD / YY	Social Security No.	Gender	Full Time Student
Applicant			<small>Please use key for relationship: 1 – Spouse 2 – Child 3 – Stepchild 4 – Legal guardian 5 – Legal custody</small>				
							<input type="checkbox"/> Yes <input type="checkbox"/> No
							<input type="checkbox"/> Yes <input type="checkbox"/> No
							<input type="checkbox"/> Yes <input type="checkbox"/> No
							<input type="checkbox"/> Yes <input type="checkbox"/> 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

I represent that all statements made herein are complete and true to the best of my knowledge. I understand that if I fail to provide any material information or if I intentionally misrepresent any material fact, such omission or intentional misrepresentation may result in the re-rating, termination or rescission of my health care coverage and/or criminal prosecution.

Your signature required

_____ **Date** _____