

Enrollment Form

For group coverage – health and/or dental



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Section 1

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

Residential Address _____
Street

City State ZIP Code + 4

Mailing Address _____
If different from residential address Street

City State ZIP Code + 4

Married? ☐ Yes ☐ No Date of Marriage _____
MM DD YYYY

Employed by _____

Actively working _____ hrs weekly for this employer

Date of Birth _____
MM DD YYYY

Social Security No. _____

Gender ☐ Male ☐ Female

Home Phone _____
Area Code

Work Phone _____
Area Code

Cell Phone _____
Area Code

Group No. _____

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:

	Health	Dental
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.

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 – Legal guardian 5 – Legal custody				
							<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 _____