Change Form

for group coverage

CLEAR DATA

BlueCross BlueShield of Kansas

www.bcbsks.com

Section 1 – Applicant Information (completion of this section is required)

☐ Check this box if applicant information has changed.

First Name | MI | Gender ☐ Male ☐ Female | Date of Birth

Last Name | Suffix | Social Security Number

Residential Address | Home Phone Number | Cell Phone Number

City | E-mail Address

State | ZIP Code | +4 | County | Employed by: USD 263 Mulvane

Mailing Address (if different from residential address) | Work Phone Number | Fax Number

City | Group Number: 09372

State | ZIP Code | +4 | County | Member ID Number

Section 2 – Adding Family Members to Coverage

If your plan is a grandfathered plan, adult dependents eligible for coverage through another employee group are not eligible for coverage through this plan.

I want to enroll in:

Employee only ☐ Health ☐ Dental

Employee and child(ren) ☐ Health ☐ Dental

Employee and spouse ☐ Health ☐ Dental

Employee and family ☐ Health ☐ Dental

Reason for change: ☐ Birth/adoption ☐ Marriage ☐ Divorce ☐ Open Enrollment

☐ Involuntary loss of coverage (give reason):

☐ Other (give reason):

Date of Occurrence

Relationship to applicant: ☐ Spouse ☐ Child ☐ Stepchild ☐ Legal Guardianship ☐ Legal Custody

First Name | MI | Gender ☐ Male ☐ Female | Date of Birth

Last Name | Suffix | Social Security Number | Date of Marriage/Adoption

Full-time student? ☐ Yes ☐ No

Relationship to applicant: ☐ Spouse ☐ Child ☐ Stepchild ☐ Legal Guardianship ☐ Legal Custody

First Name | MI | Gender ☐ Male ☐ Female | Date of Birth

Last Name | Suffix | Social Security Number | Date of Marriage/Adoption

Full-time student? ☐ Yes ☐ No

Section 2 – Adding Family Members to Coverage (continued)

Relationship to applicant: ☐ Spouse ☐ Child ☐ Stepchild ☐ Legal Guardianship ☐ Legal Custody

First Name | MI | Gender ☐ Male ☐ Female | Date of Birth

Last Name | Suffix | Social Security Number | Date of Marriage/Adoption

Full-time student? ☐ Yes ☐ No

Are you or any of your listed dependents covered by Medicare Part A and/or B? ☐ Yes ☐ No

Name of family member with coverage:

First Name | MI | Medicare ID Number

Last Name | Suffix | Part A Effective Date | Part B Effective Date

Are you entitled to Medicare due to ESRD (permanent kidney failure)? ☐ Yes ☐ No

Is anyone enrolling in this coverage entitled to benefits for surgical, medical or dental expenses from any other group insurance (excluding Medicare, Medicaid or SRS)? ☐ Yes ☐ No

Section 3 – Removing Family Members from Coverage

Check one:

☐ Change to employee only ☐ Change to employee and spouse ☐ Change to employee and child(ren)

☐ Retain family and terminate coverage for:

Reason for change:

☐ Divorce ☐ Child reaching age limit ☐ Death ☐ Other (give reason):

Date of Occurrence

Relationship to applicant: ☐ Spouse ☐ Child ☐ Stepchild ☐ Legal Guardianship ☐ Legal Custody

First Name | MI | Gender ☐ Male ☐ Female | Date of Birth

Last Name | Suffix | Social Security Number

Relationship to applicant: ☐ Spouse ☐ Child ☐ Stepchild ☐ Legal Guardianship ☐ Legal Custody

First Name | MI | Gender ☐ Male ☐ Female | Date of Birth

Last Name | Suffix | Social Security Number

Section 4 – Other Changes and Comments

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.

To process the above changes, please sign and date:

Your signature required

Applicant | Date Signed

Signature of Group Administrator | Date Signed