Change Form

for group coverage

BlueCross BlueShield of Kansas

BlueCross BlueShield Kansas Solutions

Section 1 – Member Information (completion of this section is required) CLEAR DATA

☐ Check this box if member 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

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

City Group Number

State ZIP Code +4 County Member ID Number

Section 2 – Adding Family Members to Coverage

I want to enroll in:

Employee only ☐ Health ☐ Dental Employee and spouse ☐ Health ☐ Dental

Employee and child(ren) ☐ 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): ____

Official Date of Occurrence

Important – Tobacco Use (BlueCare policies only): Answer the following questions for each dependent (age 21 and over).

Have any of your dependents 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, does your dependent agree to participate in and complete our cessation program?

Relationship to member: ☐ 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

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

Relationship to member: ☐ 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

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

Section 2 – Adding Family Members to Coverage (continued)

Relationship to member: ☐ 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 _____

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

Official Date of Occurrence _____

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

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

Last Name _____ Suffix _____ Social Security Number _____

Relationship to member: ☐ 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

Member _____ Date Signed _____

Signature of Plan Administrator _____ Date Signed _____