Change Form

for group coverage

BlueCross BlueShield of Kansas | BlueCross BlueShield Kansas Solutions

bcbsks.com

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

CLEAR DATA

☐ 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 ______

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

City ______ Group Number / Category ______

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 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): ______

Official 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 ______

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 ______

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 ______

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

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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 applying for this coverage enrolled in any other health/dental 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 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 ____ ____ ____

Plan Administrator Representative, Plan Sponsor Representative or Officer of the Company ____ Date Signed ____ ____ ____

This information is being furnished in compliance with applicable federal regulations.

This Notice has important information. This notice has important information about your application or coverage through Blue Cross and Blue Shield of Kansas. Look for key dates in this notice. You may need to take action by certain deadlines to keep your health coverage or help with costs. You have the right to get this information and help in your language at no cost. Please call 1-800-432-3990.

Discrimination is against the law.

Blue Cross and Blue Shield of Kansas (BCBSKS) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. BCBSKS does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Blue Cross and Blue Shield of Kansas:
- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact Holly Graves.

If you believe that BCBSKS has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Holly Graves, Director, Individual Sales and Customer Service, 1133 S.W. Topeka Blvd., Topeka, KS 66629-0001,
1-800-432-3990, TTY: 1-800-766-3777, Fax: 785-290-0711, CSC@bcbsks.com.

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Holly Graves is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Para obtener asistencia en español, llame al servicio de atención al cliente al número que aparece en su tarjeta de identificación.

請撥打您 ID 卡上的客服號碼以尋求中文協助。

Gọi số dịch vụ khách hàng trên thẻ ID của quý vị để được hỗ trợ bằng Tiếng Việt.

한국어로 도움을 받고 싶으시면 ID 카드에 있는 고객 서비스 전화번호로 문의해 주십시오.

Para sa tulong sa Tagalog, tumawag sa numero ng serbisyo sa customer na nasa inyong ID card.

Обратитесь по номеру телефона обслуживания клиентов, указанному на Вашей идентификационной карточке, для помощи на русском языке.

اتصل برقم خدمة العملاء الموجود على بطاقة هُويتك للحصول على المساعدة باللغة العربية.

Rele nimewo sèvis kliyantèl ki nan kat ID ou pou jwenn èd nan Kreyòl Ayisyen.

Pour une assistance en français du Canada, composez le numéro de téléphone du service à la clientèle figurant sur votre carte d'identification.

Ligue para o número de telefone de atendimento ao cliente exibido no seu cartão de identificação para obter ajuda em português.

Aby uzyskać pomoc w języku polskim, należy zadzwonić do działu obsługi klienta pod numer podany na identyfikatorze.

日本語でのサポートは、ID カードに記載のカスタマーサービス番号までお電話でお問い合わせください。

Per assistenza in italiano chiamate il numero del servizio clienti riportato nella vostra scheda identificativa.

Rufen Sie den Kundendienst unter der Nummer auf Ihrer ID-Karte an, um Hilfestellung in deutscher Sprache zu erhalten.

برای دریافت راهنمایی به زبان فارسی ، با شماره خدمات مشتری که بر روی کارت شناسایی شما درج شده است تماسبگیرید..