Change Form

for group coverage

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 McPherson College

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

City _____ Group Number 6720004

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 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): _____

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 _____