Enrollment Form

For group coverage – health and/or dental

RESET FORM

www.bcbsks.com

Section 1

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

Date of Birth ______ MM DD YYYY

Residential Address ____________________ Street

____________________ City State ZIP Code + 4

Social Security No. ______

Gender ☐ Male ☐ Female

Mailing Address If different from residential address ____________________ Street

____________________ City State ZIP Code + 4

Home Phone ______ Area Code

Work Phone ______ Area Code

Cell Phone ______ Area Code

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

Employed by McPherson College

Group No. 6720004

Actively working ______ hrs weekly for this employer

Date of Full-Time Hire ______ MM DD YYYY

If you are currently enrolled in Blue Cross and Blue Shield of Kansas coverage, 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

Section 2

If you don't know which benefit plans your company offers, please see your Group Administrator.

I want coverage for:	Health	Dental	Vision
Employee only	☐	☐	☐
Employee and spouse	☐	☐	☐
Employee and child(ren)	☐	☐	☐
Employee and family	☐	☐	☐

Participating in: **Flexible Spending Account (FSA)** ☐ Yes ☐ No

Health Savings Account (HSA) ☐ Yes ☐ No

High Deductible Health Plan (HDHP) ☐ Yes ☐ No

Option ______

Listed below are family members, including myself and my spouse, who are to be enrolled. (List last name if different.)

Last	First	M.I.	Relationship To Employee	Date of Birth MM / DD / YY	Social Security No.	Gender
Applicant			*Please use key for relationship.* 1 – Spouse 2 – Child 3 – Stepchild 4 – Legal guardian 5 – Legal custody			

Completion of the other side is required.

An Independent Licensee of the Blue Cross and Blue Shield Association.

Section 2 (continued)

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

Section 3

Online Certificates Available

☐ **Yes, I would like to view my certificates and prescription drug formulary online.**

____
E-mail Address

☐ No, please send a paper copy to me.

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** ____________