Enrollment Form

for group coverage – health and/or dental

BlueCross BlueShield of Kansas

BlueCross BlueShield Kansas Solutions

Section 1 – Applicant Information

First Name _____ MI _____ Social Security Number _____ Home Phone Number _____

Last Name _____ Suffix _____ Cell Phone Number _____ Work Phone Number _____

Gender ☐ Male ☐ Female Date of Birth _____

Mailing Address (if different from residential address) _____

Residential Address _____ City _____

City _____ State _____ ZIP Code _____ +4 _____

State _____ ZIP Code _____ +4 _____ County _____ E-mail Address _____

Section 2 – Enrollment Information

Geary County USD 475
Employer Name

Group Number _____ Date of Full-Time Hire _____

Actively working _____ hours weekly for this employer.

Check one:

☐ I am a new employee enrolling at my first opportunity.

☐ I was part-time _____ _____ _____, am now full-time.
Date of Part-Time Hire

☐ I am a rehired employee.

☐ I am a variable hour employee*, eligible as of _____ _____ _____.

My original date of hire was _____ _____ _____.

*For large groups only. See Plan Administrator.

☐ I am an existing employee enrolling due to:

- ☐ Employer's Open Enrollment
- ☐ Birth/Adoption
- ☐ Marriage
- ☐ Divorce
- ☐ Involuntary Loss of Coverage (explain) _____
- ☐ Other (give reason) _____

Official Date of Occurrence _____ _____ _____

If you are currently enrolled in Blue Cross and Blue Shield of Kansas or BlueCross BlueShield Kansas Solutions coverage, please provide your current ID number. _____
Member ID Number

If you don't know which benefit plan(s) your company offers, please see your Plan Administrator.

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

I want to participate in:

- Flexible Spending Account (FSA) ☐ Yes ☐ No
- Health Savings Account (HSA) ☐ Yes ☐ No
- High Deductible Health Plan (HDHP) ☐ Yes ☐ No
  Option _____

Important – Tobacco Use (BlueCare policies only): Answer the following questions for yourself and each dependent (age 21 and over) – Have you 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, do you agree to participate in and complete our cessation program? (continue below)

Applicant (Same as listed in Section 1):

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

Section 2A – Dependent Information

Relationship to applicant: ☐ Spouse

____ ____ _____
Date of Marriage

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

_____ ____ ____ ____ _____
Last Name Suffix Social Security Number

Type of coverage I am choosing: (check all that apply) Tobacco Use: ☐ Yes ☐ No
☐ Health ☐ Dental Cessation Program: ☐ Yes ☐ No

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

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

_____ ____ ____ ____ _____
Last Name Suffix Social Security Number

Type of coverage I am choosing: (check all that apply) Tobacco Use: ☐ Yes ☐ No
☐ Health ☐ Dental Cessation Program: ☐ Yes ☐ No

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

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

_____ ____ ____ ____ _____
Last Name Suffix Social Security Number

Type of coverage I am choosing: (check all that apply) Tobacco Use: ☐ Yes ☐ No
☐ Health ☐ Dental Cessation Program: ☐ Yes ☐ No

Section 3 – Medicare / Other Party Liability

Do you or any of your listed dependents have Medicare Parts A and/or B? ☐ Yes ☐ No

If yes, provide name of family member with coverage:

_____ ____
First Name MI

_____
Last Name

_____
Medicare Number

____ ____ _____
Part A Effective Date

____ ____ _____
Part B Effective Date

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

If yes, please provide current ID number:

_____
Current ID Number

Coverage is: ☐ Health only ☐ Dental Only
☐ Health and Dental

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

Section 4 – Authorization

By signing this authorization, I represent that the information I have stated is true to the best of my knowledge and belief and I understand that Blue Cross and Blue Shield of Kansas (BCBSKS) or BlueCross BlueShield Kansas Solutions (Solutions), independent licensees of the Blue Cross Blue Shield Association, will re-rate, terminate or rescind the contract if such information received at any time indicates the information provided in this enrollment process intentionally misrepresented a material fact or was fraudulent.

Unless you are enrolling in a Qualified Health Plan, this policy does not provide Exchange Certified pediatric dental or vision essential benefits pursuant to the Affordable Care Act and does not satisfy the "reasonable assurance" requirement.

Online Certificates Available

☐ **Yes, I would like view my certificates online.**

_____
E-mail Address

☐ No, please send a paper copy to me.

Submit

Your signature required

_____ ____ ____ _____
Applicant 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, Internal Sales and Customer Service, 1133 S.W. Topeka Blvd., Topeka, KS 66629-0001, 785-291-4375, TTY: 1-800-430-1270, Fax: 785-290-0785, CSC.SpecServ@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.

Este Aviso contiene información importante. Este aviso contiene información importante acerca de su solicitud o cobertura a través de Cruz Azul y Escudo Azul de Kansas. Preste atención a las fechas clave que contiene este aviso. Es posible que deba tomar alguna medida antes de determinadas fechas para mantener su cobertura médica o ayuda con los costos. Usted tiene derecho a recibir esta información y ayuda en su idioma sin costo alguno. Llame al 1-800-432-3990.

Thông báo này cung cấp thông tin quan trọng. Thông báo này có thông tin quan trọng bàn về đơn nộp hoặc hợp đồng bảo hiểm qua chương trình Blue Cross và Blue Shield ở Kansas. Xin xem ngày then chốt trong thông báo này. Quý vị có thể phải thực hiện theo thông báo đúng trong thời hạn để duy trì bảo hiểm sức khỏe hoặc được trợ trúp thêm về chi phí. Quý vị có quyền được biết thông tin này và được trợ giúp bằng ngôn ngữ của mình miễn phí. Vui lòng gọi đến số 1-800-432-3990.

本通知有重要的訊息。本通知有關於您透過堪薩斯州的 Blue Cross 和 Blue Shield 提交的申請或保險的重要訊息。請留意本通知內的重要日期。您可能需要在截止日期之前採取行動, 以保留您的健康保險或者費用補貼。您有權利免費以您的母語得到本訊息和幫助。請撥打 1-800-432-3990。

Diese Benachrichtigung enthält wichtige Informationen. Diese Benachrichtigung enthält wichtige Informationen bezüglich Ihres Antrags auf Krankenversicherungsschutz durch Blaues Kreuz und Blaues Schild von Kansas. Suchen Sie nach wichtigen Terminen in dieser Benachrichtigung. Sie könnten bis zu bestimmten Stichtagen handeln müssen, um Ihren Krankenversicherungsschutz oder Hilfe mit den Kosten zu behalten. Sie haben das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Rufen Sie an unter 1-800-432-3990.

본 통지서에는 중요한 정보가 들어 있습니다. 즉 이 통지서는 귀하의 신청에 관하여 그리고 캔사스의 Blue Cross와 Blue Shield를 통한 커버리지에 관한 정보를 포함하고 있습니다. 본 통지서에서 핵심이 되는 날짜들을 찾으십시오. 귀하는 귀하의 건강 커버리지를 계속 유지하거나 비용을 절감하기 위해서 일정한 마감일까지 조치를 취해야 할 필요가 있을 수 있습니다. 귀하는 이러한 정보와 도움을 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 1-800-432-3990으로 전화하십시오.

ແຈ້ງການນີ້ມີຂໍ້ມູນສຳຄັນ. ແຈ້ງການນີ້ມີຂໍ້ມູນສຳຄັນກ່ຽວກັບຄຳຮ້ອງສະໝັກ ຫຼື ຄວາມຄຸ້ມຄອງປະກັນໄພຂອງທ່ານຜ່ານ Blue Cross ແລະ Blue Shield ລັດ Kansas. ຈົ່ງກວດເບິ່ງວັນທີສຳຄັນຕ່າງໆໃນແຈ້ງການນີ້. ທ່ານອາດຈະຈຳເປັນຕ້ອງດຳເນີນການຕາມກຳນົດເວລາສະເພາະຕ່າງໆ ເພື່ອຮັກສາຄວາມຄຸ້ມຄອງປະກັນສຸຂະພາບຂອງທ່ານ ຫຼື ການຊ່ວຍເຫຼືອເລື່ອງຄ່າໃຊ້ຈ່າຍຕ່າງໆ. ທ່ານມີສິດໄດ້ຮັບຂໍ້ມູນນີ້ ແລະ ຄວາມຊ່ວຍເຫຼືອ ເປັນພາສາຂອງທ່ານໂດຍບໍ່ເສຍຄ່າ. ກະລຸນາໂທຫາ 1-800-432-3990.

يحوي هذا الاشعار معلومات هامة. يحوي هذا الاشعار معلومات مهمة بخصوص طلبك للحصول على التغطية من خلال بلو كروس آند بلو شيلد أوف كانساس. ابحث عن التواريخ الهامة في هذا الاشعار. قد تحتاج لاتخاذ اجراء في تواريخ معينة للحفاظ على تغطيتك الصحية او للمساعدة في دفع التكاليف. لك الحق في الحصور على المعلومات والمساعدة بلغتك من دون أي تكلفة. اتصل بالرقم 1-800-432-3990.

Ang Paunawa na ito ay naglalaman ng mahalagang impormasyon. Ang paunawa na ito ay naglalaman ng mahalagang impormasyon tungkol sa iyong aplikasyon o pagsakop sa pamamagitan ng Asul na Krus at Asul na Kalasag ng Kansas. Tingnan ang mga mahalagang petsa dito sa paunawa. Maaring mangailangan ka na magsagawa ng hakbang sa ilang mga itinakdang panahon upang mapanatili ang iyong pagsakop sa kalusugan o tulong na walang gastos. May karapatan ka na makakuha ng ganitong impormasyon at tulong sa iyong wika ng walang gastos. Mangyaring tumawag sa 1-800-432-3990.

ဤသတိပေးချက်တွင် အရေးကြီးသော အချက်အလက်များ ပါရှိပါသည်။ ဤသတိပေးချက်တွင် သင့် အပလီကေးရှင်း သို့မဟုတ် ဘလူးခရော့စ် (Blue Cross) နှင့် ကန်ဆက်(Kansas) ပြည်နယ်၏ ဘလူးရှီး၁(Blue Shield) မှ အခွင့်အရေးအကြောင်း အရေးကြီးသည့် အချက်အလက်များ ပါရှိပါသည်။ ဤအသိပေးချက်တွင် အဓိကနေ့ရက်များကို ရှာဖွေပါ။ သင့်ကျန်းမာရေး စောင့်ရှောက်မှု အခွင့်အရေးကို ရရှိရန် သို့မဟုတ် ငွေကုန်ကြေးကျခံ၍ ကူညီမှုကို ရရှိနိုင်ရန် သတ်မှတ်ရက်အတိုင်း လုပ်ဆောင်ရန် လိုအပ်ပါသည်။ သင့်တွင် ဤအချက်အလက်များကို ရရှိရန် နှင့် သင့်ဘာသာစကားဖြင့် ကုန်ကျစရိတ်မရှိဘဲ အကူအညီရပိုင်ခွင့် ရှိပါသည်။ ကျေးဇူးပြု၍ 1-800-432-3990 ကို ခေါ်ဆိုပါ။

Cet avis fournit des informations importantes. Cet avis fournit des informations importantes sur votre demande ou sur votre assurance auprès de Croix bleue et bouclier bleu du Kansas. Recherchez les dates clés dans le présent avis. Vous devrez peut-être prendre des mesures avant une certaine échéance pour conserver votre assurance santé, faute de quoi vous devrez financer les coûts. Vous êtes autorisé à bénéficier gratuitement de ces informations et de cette aide dans votre langue. Veuillez appeler le 1-800-432-3990.

この通知には重要な情報が含まれています。この通知には、カンザス州の健康保険組合および医療保険組合の申請または補償範囲に関する重要な情報が含まれています。この通知に記載されている重要な日付をご確認ください。健康保険や有料サポートを維持するには、特定の期日までに行動を取らなければならない場合があります。ご希望の言語による情報とサポートが無料で提供されます。1-800-432-3990 までお電話ください。

Настоящее уведомление содержит важную информацию. Это уведомление содержит важную информацию о вашем заявлении или страховом покрытии через Синий крест и Синий щит Канзаса. Посмотрите на ключевые даты в настоящем уведомлении. Вам, возможно, потребуется принять меры к определенным предельным срокам для сохранения страхового покрытия или помощи с расходами. Вы имеете право на бесплатное получение этой информации и помощь на вашем языке. Звоните по номеру 1-800-432-3990.

Tsab ntawv tshaj xo no muaj cov ntshiab lus tseem ceeb. Tsab ntawv tshaj xo no muaj cov ntsiab lus tseem ceeb txog koj daim ntawv thov kev pab los yog koj qhov kev pab cuam los ntawm Blue Cross thiab Blue Shield ntawm Kansas. Saib cov caij nyoog los yog tej hnub tseem ceeb uas sau rau hauv daim ntawv no kom zoo. Tej zaum koj kuj yuav tau ua qee yam uas peb kom koj ua tsis pub dhau cov caij nyoog uas teev tseg rau hauv daim ntawv no mas koj thiaj yuav tau txais kev pab cuam kho mob los yog kev pab them tej nqi kho mob ntawd. Koj muaj cai kom lawv muab cov ntshiab lus no uas tau muab sau ua koj hom lus pub dawb rau koj. Thov hu rau tus xov tooj 1-800-432-3990.

این اطلاعیه حاوی اطلاعات مهمی است. این اطلاعیه حاوی اطلاعات مهمی در مورد فرم تقاضا یا پوشش بیمه ای شما توسط صلیب آبی و سپر آبی کانزاس می باشد. به تاریخ های مهم در این اطلاعیه توجه نمایید. ممکن است نیاز داشته باشید تا قبل از تاریخ خاصی اقدامی انجام دهید تا پوشش سلامت خود را نگه دارید یا در مورد هزینه ها کمک دریافت کنید. این حق شماست تا این اطلاعات و کمک را برای زبان خود و به رایگان دریافت کنید. لطفاً با شماره تلفن 1-800-432-3990 تماس بگیرید.

Ilani hii ina Taarifa Muhimu. Ilani hii ina taarifa muhimu kuhusu maombi yako au chanjo kupitia Msalaba wa Samawati na Ngao ya Samawati ya Kansas. Angalia kwa ajili ya tarehe muhimu katika ilani hii. Waweza pia hitajika kuchukua hatua katika muda ulio pangwa fulani ili uweze ku hifadhi bima yako ya afya au msaada wa gharama zake. Una haki ya kupata habari hii na msaada kwa lugha yako bila gharama. Tafadhali piga nambari kwa 1-800-432-3990.