

Change Form

For group coverage



www.bcbsks.com

Section 1

Always complete this section:

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

Physical Address _____
Street
City State ZIP Code County

Mailing Address _____
if different from Street/P.O. Box physical address
City State ZIP Code County

Gender Male Female Date of Birth ____/____/____
MM DD YYYY

Social Security No. _____ Home Phone No. (____)____
Area Code

Employed by _____ Work Phone No. (____)____
Area Code

Member ID No. _____ Group No. _____

Section 2

To add family members, complete this section:

Change to family due to:

- Birth/Adoption Marriage
- Divorce Involuntary Loss of Coverage
- Open Enrollment Other (Give reason) _____

I want to enroll in:	Health	Dental
Myself only	<input type="checkbox"/>	<input type="checkbox"/>
Myself and my spouse	<input type="checkbox"/>	<input type="checkbox"/>
Myself and my child(ren)	<input type="checkbox"/>	<input type="checkbox"/>
Myself and my family	<input type="checkbox"/>	<input type="checkbox"/>

Date of this occurrence ____/____/____
MM DD YYYY

Spouse (complete this section if spouse is included in plan)

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

Gender Male Female Date of Birth ____/____/____
MM DD YYYY

Social Security No. _____ Date of Marriage ____/____/____
MM DD YYYY

Dependent

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

Gender Male Female Date of Birth ____/____/____ Full Time Student? Yes No
MM DD YYYY

Social Security No. _____ Relationship to employee: Child Stepchild Other

Dependent

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

Gender Male Female Date of Birth ____/____/____ Full Time Student? Yes No
MM DD YYYY

Social Security No. _____ Relationship to employee: Child Stepchild Other

Section 2 (cont'd)

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

Name of family member with coverage:

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

Medicare No. _____ Part A effective date ____/____/____
MM DD YYYY

Part B effective date ____/____/____
MM DD YYYY

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, SRS, Medicaid)? Yes No

To drop family members, complete this section:

Check one: Change to myself only Change to myself and my spouse Change to myself and my child(ren)

Retain family and terminate coverage for: _____

Divorce Death Child married Other (give reason): _____

Date of occurrence ____/____/____
MM DD YYYY

Section 3

Last	Name		Date of Birth		
	First	M.I.	Month	Day	Year

Other changes and comments:

Section 4

To receive credit for any waiting periods for pre-existing conditions under your previous coverage, you must submit a Certificate of Creditable Coverage. Contact your previous employer and/or insurer.

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 misrepresent any material fact, such omission or 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

_____ Date ____/____/____

Signature of group administrator _____ Date ____/____/____