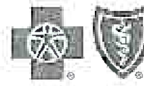
COVERAGE APPLICATION

TRANSFER FORM/GROUP COVERAGE



BlueCross BlueShield of Kansas PremierBlue

www.bcbsks.com

Name ______ Last ______ First ______ M.I.

Address ______ Street

______ City ______ State ______ ZIP ______ County

Name of employer ______

Group No. ______

I actively work______ hours each week for this employer.

Social Security No. ______

Date of Birth ___/___/___

Gender: ☐ Male ☐ Female

Work phone (   ) ______ Area Code

Home phone (   ) ______ Area Code

Date of hire ___/___/___

Rehire/recall date ___/___/___

New Employee (check one)

☐ I am enrolling at my first opportunity

☐ I am replacing my current Blue Cross and Blue Shield of Kansas coverage.

I.D. # ______

Existing Employee (check one)

☐ I am enrolling due to a qualifying event such as birth, adoption or marriage.

Qualifying Event ______ Date of Event ___/___/___

☐ I am enrolling during my employer's annual open enrollment period.

I am applying for health coverage for: (check one)

☐ Myself ☐ Myself and my spouse ☐ Myself and my child(ren) ☐ My family

If more than one health option offered by group: (check one)

☐ Blue Cross and Blue Shield Health ☐ Blue Select Health ☐ Blue Choice Health

☐ Premier Blue ☐ Premier Blue with Self-Referral Option

Triple Option ☐ Option 1 ☐ Option 2 ☐ Option 3

If dental offered by group, I am applying for coverage for: (check one)

☐ Myself ☐ Myself and my spouse ☐ Myself and my child(ren) ☐ My family

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.

Listed below are family members, including myself and my spouse, who are to be enrolled. (List last name if different.) If applying for Premier Blue or Blue Select, the first and last name of your primary care physician is required.

Last	First	M.I.	Relationship To Employee	Date of Birth MM / DD / YY	Social Security No.	Gender	Full Time† Student	Primary Care Physician
Applicant								Name: City:
				/ /			☐ Yes ☐ No	Name: City:
				/ /			☐ Yes ☐ No	Name: City:
				/ /			☐ Yes ☐ No	Name: City:
				/ /			☐ Yes ☐ No	Name: City:
				/ /			☐ Yes ☐ No	Name: City:

†If your group requires full time student coverage:

College/trade school name ______ Number of hours attending______

40-127 6/03

*Independent Licensees of the Blue Cross and Blue Shield Association.

Please turn over →