

Change Form



Blue Cross
Blue Shield
of Kansas

Premier Blue

Independent Licensees of the Blue Cross and Blue Shield Association.

www.bcbsks.com

For group coverage

Section 1

Always complete this section

Member's Name _____ Date of Birth _____ Social Security No. _____
Last First M.I. Mo. Day Yr.

Spouse's Name _____ Date of Birth _____ Social Security No. _____
Last First M.I. Mo. Day Yr.

Address _____ County _____ City _____ State _____ ZIP _____
Last First M.I. Mo. Day Yr. Street or Box Number

Home Phone (____) _____ Work Phone (____) _____

Member's Employer _____ Group Number _____ Insured's Identification # _____

To add family members complete this section

Change to family because of:
 Marriage Adoption Birth of Child Other _____
 Date of Occurrence _____
Mo. Day Yr.

Add spouse and/or dependent child(ren)

I want to enroll in:

Employee Only (Single)	Health <input type="radio"/>	Drug <input type="radio"/>	Dental <input type="radio"/>
Employee/Spouse/Child(ren) (Family)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Employee/Spouse	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Employee/Child(ren)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

To receive credit for any waiting period for pre-existing conditions under previous coverage a Certificate of Creditable Coverage must be submitted. Contact a previous employer and/or insurer.

Last	Name First	M.I.	Relationship to Employee	Date of Birth			Social Security No	Gen-der	Full Time Student	**Primary Care Physician	
				Mo	Day	Yr					
										Yes <input type="checkbox"/> No <input type="checkbox"/>	Name: City:
										Yes <input type="checkbox"/> No <input type="checkbox"/>	Name: City:
										Yes <input type="checkbox"/> No <input type="checkbox"/>	Name: City:
										Yes <input type="checkbox"/> No <input type="checkbox"/>	Name: City:

*Name of college/trade school _____ Number of hours enrolled _____

**For Blue Select or Premier Blue* only.

Section 2

1. Is anyone applying for this coverage entitled to benefits from any other group insurance (excluding Medicare, SRS and Medicaid) for surgical, medical or dental expenses? Yes No
 Coverage is: Health only Dental only Health and Dental

2. Name of family member(s) with other coverage _____

3. Name of employer providing other coverage _____

Address of employer _____
Street

_____ City _____ State _____ ZIP _____ County

4. Name of insurance company _____

Address of insurance company _____
Street

_____ City _____ State _____ ZIP _____ County

Type of coverage Individual Family ID/Policy No. _____

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

Name of family member with coverage _____

Medicare Number _____

Effective date Part A _____ Effective date Part B _____
Mo. Day Yr. Mo. Day Yr.

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