Dependent Child Affidavit

BlueCross BlueShield of Kansas

Section 1 – Insurance Information

CLEAR DATA

Children in your household other than by birth or adoption may be included in your family contract, **if dependent criteria are met.** To consider the dependent for coverage, the following must be completed, signed and sworn to in front of a notary, and returned to Blue Cross and Blue Shield of Kansas.

Insured ID Number

Group ID Number

Section 2 – Affidavit

STATE OF KANSAS)
) ss.
COUNTY OF _____)

The undersigned, _____, being first duly sworn, deposes and states that:

1. My name is _____, and I am of legal age.

2. I have **legal custody** of _____ (child's full name),

date of birth ____/____/____ (MM/DD/YYYY), pursuant to the court order issued by _____

(name of court) on ____/____/____ (MM/DD/YYYY) (date of court order), or

3. I have enclosed a file-stamped copy of the court order granting me legal custody of the above-referenced child.

4. I have **legal guardianship** of _____ (child's full name),

date of birth ____/____/____ (MM/DD/YYYY), pursuant to the court order issued by _____

(name of court) on ____/____/____ (MM/DD/YYYY) (date of court order), or

5. I have enclosed a file-stamped copy of the Letters of Guardianship issued for the above-referenced child.

Section 3 – Authorization

IN WITNESS WHEREOF, the undersigned has executed this legal document on the ____ day of _____ (month), _____ (year).

I certify that this information is true to the best of my knowledge and agree to notify Blue Cross and Blue Shield of Kansas immediately of any changes in status.

Your signature required

_____ (Insured) ____ ____ _____ (Date Signed)

Subscribed and sworn before me on this ____ day of _____ (month), _____ (year).

Notary Public _____ Notary Seal

Thank you – Please use the instructions below to return this form.

By mail:
Blue Cross and Blue Shield of Kansas
P.O. Box 517
Topeka, KS 66601-0517

By fax: 785-290-0770

Have questions? Call us at 1-800-432-3990
In Topeka, call 291-4180.

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, Individual Sales and Customer Service, 1133 S.W. Topeka Blvd., Topeka, KS 66629-0001,
1-800-432-3990, TTY: 1-800-766-3777, Fax: 785-290-0711, CSC@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.

Para obtener asistencia en español, llame al servicio de atención al cliente al número que aparece en su tarjeta de identificación.

請撥打您 ID 卡上的客服號碼以尋求中文協助。

Gọi số dịch vụ khách hàng trên thẻ ID của quý vị để được hỗ trợ bằng Tiếng Việt.

한국어로 도움을 받고 싶으시면 ID 카드에 있는 고객 서비스 전화번호로 문의해 주십시오.

Para sa tulong sa Tagalog, tumawag sa numero ng serbisyo sa customer na nasa inyong ID card.

Обратитесь по номеру телефона обслуживания клиентов, указанному на Вашей идентификационной карточке, для помощи на русском языке.

اتصل برقم خدمة العملاء الموجود على بطاقة هُويتك للحصول على المساعدة باللغة العربية.

Rele nimewo sèvis kliyantèl ki nan kat ID ou pou jwenn èd nan Kreyòl Ayisyen.

Pour une assistance en français du Canada, composez le numéro de téléphone du service à la clientèle figurant sur votre carte d'identification.

Ligue para o número de telefone de atendimento ao cliente exibido no seu cartão de identificação para obter ajuda em português.

Aby uzyskać pomoc w języku polskim, należy zadzwonić do działu obsługi klienta pod numer podany na identyfikatorze.

日本語でのサポートは、ID カードに記載のカスタマーサービス番号までお電話でお問い合わせください。

Per assistenza in italiano chiamate il numero del servizio clienti riportato nella vostra scheda identificativa.

Rufen Sie den Kundendienst unter der Nummer auf Ihrer ID-Karte an, um Hilfestellung in deutscher Sprache zu erhalten.

برای دریافت راهنمایی به زبان فارسی ، با شماره خدمات مشتری که بر روی کارت شناسایی شما درج شده است تماسبگیرید..