Change Form

for BlueCare℠ non-group coverage

Note: This form is not intended for use by Marketplace enrollees.

For office use only:

Identifier

Section 1 – Applicant Information

First Name | MI | Gender ☐ Male ☐ Female | Date of Birth

Last Name | Suffix | Social Security Number

Residential Address | Home Phone Number | Cell Phone Number

City | E-mail Address

State | ZIP Code | +4 | County | Work Phone Number

Mailing Address (if different from residential address) | Member ID Number

City

State | ZIP Code | +4

Section 2 – Change of Name or Address (Please check which address you would like to change.)

☐ Change name to:

First Name | MI

Last Name | Suffix

Change address: ☐ Residential ☐ Mailing ☐ Both

Street Address or P.O. Box

City

State | ZIP Code | +4

Section 3 – Add Family Members to Coverage

☐ Please add family members to my existing policy.

Give reason for change: ☐ Birth/adoption ☐ Marriage ☐ Divorce ☐ Involuntary loss of coverage ☐ Other

Official Date of Occurrence

Important – Tobacco Use: Answer the following tobacco use question for each family member:

Have any of your dependents 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?

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

First Name | MI | Gender ☐ Male ☐ Female | Date of Birth

Last Name | Suffix | Social Security Number | Date of Adoption

Tobacco use: ☐ Yes ☐ No

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

First Name | MI | Gender ☐ Male ☐ Female | Date of Birth

Last Name | Suffix | Social Security Number | Date of Adoption

Tobacco use: ☐ Yes ☐ No

Independent licensees of the Blue Cross Blue Shield Association.

Section 3 – Add Family Members to Coverage (continued)

Are you or any of your listed dependents covered by Medicare Part A and/or B? ☐ Yes ☐ No

Name of family member with coverage:

First Name ______ MI ______ Medicare ID Number ______

Last Name ______ Suffix ______ Part A Effective Date ______ Part B Effective Date ______

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

Is anyone applying for this coverage enrolled in any other health/dental insurance (excluding Medicare, Medicaid or SRS)? ☐ Yes ☐ No

Section 4 – Remove Family Members from Coverage

Check one:

☐ Change to myself only ☐ Change to myself/my spouse ☐ Change to myself/my child(ren)

☐ Retain family and terminate coverage for: ______

Give reason for change:

☐ Divorce ☐ Child reaching age limit ☐ Death ☐ Other (give reason): ______

Date of Occurrence ______

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

First Name ______ MI ______ Gender ☐ Male ☐ Female Date of Birth ______

Last Name ______ Suffix ______ Social Security Number ______

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

First Name ______ MI ______ Gender ☐ Male ☐ Female Date of Birth ______

Last Name ______ Suffix ______ Social Security Number ______

Section 5 – Other Changes and Comments

______

______

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 intentionally misrepresent any material fact, such omission or intentional misrepresentation may result in the re-rating, termination or rescission of my health care coverage and/or criminal prosecution.

Your signature required ______ Applicant (Signature of parent/guardian if other than applicant) ______ Date Signed

Your signature required ______ Spouse (If applying for coverage) ______ Date Signed

______ Dependent child (If 18 or older when added/removed from coverage) ______ Date Signed

After completion of this form, you can mail it to:

Blue Cross and Blue Shield of Kansas
PO Box 239
Topeka, KS 66601

Or fax it to:

785-290-0770

bcbsks.com

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..