Income Verification Form

for renewing members

BlueCross BlueShield of Kansas

ValueBlue℠

Section 1 – Applicant Information

CLEAR DATA

First Name _____ MI _____

Last Name _____ Suffix _____

If we need additional information, we will try to contact you by phone. Which time is best to reach you? ☐ AM ☐ PM

Daytime Phone Number _____ _____ _____

Home Phone Number _____ _____ _____

Residential Address _____

City _____

State _____ ZIP Code _____ +4 _____ County _____

Mailing Address (if different from residential address) _____

City _____

State _____ ZIP Code _____ +4 _____ County _____

Section 2 – Qualifications

Income verification is necessary to complete the process and determine eligibility. This income information will be reviewed annually. At right, you will find the 2017 Federal Poverty Level Table.

You must:

- Live in the state of Kansas, except Johnson and Wyandotte counties.
- Complete the Income Verification Form.
- List all household members.*
- Sign and date the Income Verification Form.
- **Provide the gross annual household income. This would include the most current federal tax returns for all household income.**
- If self-employed, provide your most current tax return, **including all schedules and attachments.**

2017 Federal Poverty Level Percentages – Monthly

Household Size	200%
1	$ 2,010
2	$ 2,706
3	$ 3,404
4	$ 4,100
5	$ 4,796
6	$ 5,494
7	$ 6,190
8	$ 6,886

For each additional person, add $696

*Household income refers to all income earned by the Insured(s) and any spouse or dependent children of the Insured(s) age 18 and over. Household income shall also include all income of any individual or individuals who claim an Insured as a dependent for tax purposes.

Section 3 – Household Members

Please list everyone in your household, starting with yourself on the first line.

Full Name	Relationship to you	Date of Birth
	Self	

Section 4 – Health Insurance

Is anyone included on your current contract or certificate covered under any other health insurance plan? ☐ Yes ☐ No

If yes, please explain: _____

_____

_____

Please continue on the next page.

Section 5 – Income Information

Does anyone receive the following types of income? ☐ Yes ☐ No

If yes, complete the chart below and attach proof of income to include the most current federal income tax returns for all working adults 18 years of age and older. Please use an additional sheet of paper if you need more space.

- child support
- unemployment
- employment/tips
- pensions
- rental income
- military allotments
- alimony
- Social Security/SSI
- veteran's benefits
- student grants
- worker's compensation
- monthly income from family
- other (investment income, interest, etc.)

If no taxes were filed, please furnish at least one of the following:

- W-2's, if applicable, for the most current federal income tax year, for all working adults 18 year of age and older.
- 1099's, if applicable, for the most current federal income tax year, for all working adults 18 years of age and older.
- Paycheck stubs, if applicable, from all employers during the most current federal income tax year, for all working adults 18 years of age and older.
- If anyone listed on the income verification form was financially supported by another individual, please submit a letter from the individual supporting said individual(s).

Please use an additional sheet of paper if you need more space.

Name of Person Working or Receiving Income	Type of Income	Employer Name and Telephone Number (if applicable)	Amount Received Before Taxes/Deductions	Amount of Tips or Commission	Hourly Wage and Hours Worked Per Week

Section 6 – Self-Employment

Please list anyone who is self-employed and **attach a copy of their most current complete tax return.**

Name	Name and Type of Business	Hours Worked Per Week	Total Monthly Income Before Expenses Are Deducted	Total Monthly Business Expenses

Section 7 – Important Information and Authorization

Important Information for Your Income Verification Form and Authorization to Release Information: Please read the following important statements and sign below to complete your Income Verification Form.

- I represent that I am requesting health coverage and that I must be a resident of the state of Kansas.
- I represent I have provided current income, address and household composition information.
- I understand any policy issued to me will be issued in reliance on the information I have provided on this Income Verification Form.
- I understand that Blue Cross and Blue Shield of Kansas (BCBSKS) will re-rate, terminate or rescind the contract for the following conditions: 1) if information received within two years after the date the contract becomes effective indicates information provided on this Income Verification Form was incorrect; 2) if such information received at any time indicates the information provided in this Income Verification Form intentionally misrepresented a material fact or was fraudulent.
- I understand no representative of BCBSKS has the authority to waive any information required on this Income Verification Form; or to bind BCBSKS to provide coverage for me or any of my dependents or to waive, alter or change the provisions of the contract which may be issued.
- I understand that by signing this Income Verification Form, I authorize any former and/or current employer (if applicable), insurance company, or any other organization or person who has information or obtains information concerning me or any of my dependents covered by this form, to give it to BCBSKS.
- I understand that my signature (and my spouse's, if applicable) verify that I (we) have read all of the information on this form and represent that it is correct and accurate. I understand BCBSKS shall have no liability for payment of services until all of the following occur: a) the enrollment form has been received and approved; b) an official contract has been issued and delivered; and c) the full first premium has actually been paid to and accepted by BCBSKS.
- **I understand all coverage is subject to the income information provided on this form remaining unchanged to the effective date of coverage. If any change in income occurs before the effective date of coverage, I understand I must notify the BCBSKS Underwriting Department at 1-800-432-0216. (A photographic copy of this authorization shall be as valid as the original.)**
- I represent that all statements made herein are complete and true to the best of my knowledge. I understand that failure to provide any material information or if I intentionally misrepresent any material fact, such omission or intentional misrepresentation may result in re-rating, termination or recission of my health care coverage and/or criminal prosecution.

Your signature required

_____ ____ ____ _____

Applicant (Signature of parent/guardian if other than applicant) Date Signed

_____

Print Name

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..