Group Secure 300 Cancer Plan and Group Secure Hospital Indemnity Plan Enrollment Form

for group coverage

BlueCross BlueShield Kansas

IMPORTANT: This is a fixed indemnity policy, NOT health insurance.

This fixed indemnity policy may pay you a limited dollar amount if you're sick or hospitalized. You're still responsible for paying the cost of your care.

- The payment you get isn't based on the size of your medical bill.
- There might be a limit on how much this policy will pay each year.
- This policy isn't a substitute for comprehensive health insurance.
- Since this policy isn't health insurance, it doesn't have to include most Federal consumer protections that apply to health insurance.

Looking for comprehensive health insurance?

- Visit **HealthCare.gov** or call **1-800-318-2596** (TTY: 1-855-889-4325) to find health coverage options.
- To find out if you can get health insurance through your job, or a family member's job, contact the employer.

Questions about this policy?

- For questions or complaints about this policy, contact your State Department of Insurance. Find their number on the National Association of Insurance Commissioners' website (naic.org) under "Insurance Departments."
- If you have this policy through your job, or a family member's job, contact the employer.

Section 1 – Applicant Information

CLEAR DATA

First Name _____ MI _____

Last Name _____ Suffix _____

Residential Address _____

City _____

State _____ ZIP Code _____ +4 _____ County _____

Mailing Address (if different from residential address) _____

City _____

State _____ ZIP Code _____ +4 _____

Gender ☐ Male ☐ Female

Date of Birth _____ / _____ / _____

Social Security Number _____-_____-_____

Home Phone Number (_____) _____-_____

Cell Phone Number (_____) _____-_____

E-mail Address _____

Please continue on the next page.

Section 2 – Election Offerings

Employer Name: ____________________

Group Number: ____________________ Date of Full-Time Hire: ____ /____ /______

Applying for:
- ☐ Group Secure 300 Cancer
- ☐ Group Secure HIP
- ☐ Both

Requested Effective Date: ____ /____ /______

Does this applicant and all family members enrolling have health insurance coverage as an individual or through an employer? ☐ Yes ☐ No

If no, please include person's name without coverage: ____________________

Section 3 – Dependent Information – Complete all fields below for each dependent being added.

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: ____-____-______

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 4 – Authorization

Important information to represent your application:

- Any contract issued to you as a result of this application will be issued in reliance on information you provide on this form. If you intentionally or unintentionally fail to provide complete, accurate and correct information, the contract shall be rescinded with all premiums refunded to you, less amounts paid for benefits under the contract.
- No representative of Blue Cross and Blue Shield of Kansas (BCBSKS) or any other entity has the authority to waive any of the information required on this form to bind BCBSKS to coverage of the applicants, or to waive, alter or amend any provision of any contract which may be issued to you.
- I understand coverage is subject to the health of all applicants on this application remaining unchanged to the effective date of coverage. If any change in health occurs before the effective date of coverage, I understand I must notify the BCBSKS underwriting department at 1-800-432-0216.

By signing this authorization, I represent that the information I have stated is true to the best of my knowledge and belief and I understand that Blue Cross and Blue Shield of Kansas will re-rate or terminate the contract if such information received at any time indicates the information provided in this enrollment process intentionally misrepresented a material fact or was fraudulent.

Your signature required

Applicant's Signature: ____________________ Date Signed: ____ /____ /______

Print Name: ____________________