Application for Secure 300 Cancer Plan℠ and Secure Hospital Indemnity Plan℠

BlueCross BlueShield Kansas

Section 1 – Applicant Information

CLEAR DATA

First Name _____ MI _____

Last Name _____ Suffix _____

Residential Address _____

City _____

State _____ ZIP Code _____ +4 _____

Gender ☐ Male ☐ Female

Date of Birth _____ / _____ / _____

Social Security Number _____-_____-_____

Phone Number (_____) _____-_____

Postal Address _____

City _____

State _____ ZIP Code _____ +4 _____

NOTE: Coverage only available to Kansas residents.

Section 2 – Coverage Information

Do you and all family members have health insurance coverage as an individual or through an employer? ☐ Yes ☐ No

If no, name of person(s) without coverage _____

Are you presently covered by Blue Cross and Blue Shield of Kansas? ☐ Yes ☐ No

If yes, provide ID Number _____

Group Number (if applicable) _____

You are applying for: (Check one)

☐ Secure 300 Cancer Plan (Secure 300)

☐ Secure Hospital Indemnity Plan (S-HIP)

☐ Both (double protection and good value)

Direct enrollment with Blue Cross and Blue Shield of Kansas ONLY:

☐ I would like to upgrade my existing Plan 150 Cancer Policy to Secure 300

☐ I would like to upgrade my existing HIP policy to Secure HIP

Your effective date must not be more than 6 months from today. If left blank, your effective date will be the first of the month following receipt of this application.

_____ / _____ / _____
Requested Effective Date

If applying for Cancer Plan:

Do you or any family member enrolling have cancer now or have had cancer in the past 5 years in any form? ☐ Yes ☐ No

If yes, name of person(s) affected _____

You want to enroll in: (Check one)

☐ Individual (under age 65)

☐ Individual/Spouse (under age 65)

☐ Individual/Children (under age 65)

☐ Individual/Spouse/Children (under age 65)

☐ Individual (over age 65)

FOR OFFICE USE ONLY		
Reference No.	Rep No.	Effective Date

Please continue on the next page.

Section 3 – Spouse and Dependent Information (continued)

Dependent must be under age 23 and a dependent either naturally, through adoption, as a stepchild or you must have legal guardianship or legal custody.

Relationship to applicant: ☐ Spouse

_____ /_____ /_______
Date of Marriage

First Name ________ MI ____ Gender ☐ Male ☐ Female _____ /_____ /_______ Date of Birth

Last Name ________ _____-_____-________ Social Security Number

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

First Name ________ MI ____ Gender ☐ Male ☐ Female _____ /_____ /_______ Date of Birth

Last Name ________ _____-_____-________ Social Security Number

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

First Name ________ MI ____ Gender ☐ Male ☐ Female _____ /_____ /_______ Date of Birth

Last Name ________ _____-_____-________ Social Security Number

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

First Name ________ MI ____ Gender ☐ Male ☐ Female _____ /_____ /_______ Date of Birth

Last Name ________ _____-_____-________ Social Security Number

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

First Name ________ MI ____ Gender ☐ Male ☐ Female _____ /_____ /_______ Date of Birth

Last Name ________ _____-_____-________ Social Security Number

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

First Name ________ MI ____ Gender ☐ Male ☐ Female _____ /_____ /_______ Date of Birth

Last Name ________ _____-_____-________ Social Security Number

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

First Name ________ MI ____ Gender ☐ Male ☐ Female _____ /_____ /_______ Date of Birth

Last Name ________ _____-_____-________ Social Security Number

Please continue on the next page.

Section 4 – Authorization

Please read the following important information and sign below to represent your application.

- **Applicable to Cancer Plan applicants only:** I hereby authorize any licensed physician, practitioner, hospital, clinic, or other medical facility, insurance company, or any other organization, association or person who has or obtains information or knowledge of any person covered by this application, or of our health to give it to Blue Cross and Blue Shield of Kansas (BCBSKS). A photographic copy of this authorization should be as valid as the original. Your authorization for medical release is only valid for a period up to, but not extending beyond, 24 months.
- 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 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.

Your signature required

_____ _____ / _____ / _____
Applicant Date Signed

_____
Print Name

Important notice regarding Cancer Plan and HIP coverage:
This is a supplement to health insurance and is not a substitute for major medical coverage. Lack of major medical coverage (or other minimum essential coverage) may result in an additional payment with your taxes.

Section 5 – Proxy

I hereby appoint the board of directors ("Board") of Blue Cross and Blue Shield of Kansas, Inc., ("Company") as my proxy to act on my behalf at all annual meetings of the policyholders of the Company. This appointment shall include such persons as the Board may designate by resolution to act on its behalf. This proxy gives the Board, or its designee, full power to vote for me on all matters that may be voted upon at any annual meeting. This proxy, unless revoked, shall remain in effect during my membership in the Company. I may revoke this proxy in writing by advising the Company of such at least ten (10) days prior to any meeting. I may also revoke my proxy by attending and voting in person at any annual meeting.

☐ Yes ☐ No

Your signature required

_____ _____ / _____ / _____
Applicant Date Signed

_____
Print Name

Please mail, email or fax this form when completed.
Mail form to:
Blue Cross and Blue Shield of Kansas
P.O. Box 517
Topeka, KS 66601-0517

Email form to indsales@bcbsks.com

Fax form to 785-290-0716