Income Verification Form

for renewing members

BlueCross BlueShield 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

(_____) _____-_____ Home Phone Number

(_____) _____-_____ Cell 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 2025 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.**

Value Blue - 2025 Annual / Monthly Poverty Levels United States & DC

Person in Family or Household	100% Annual	Monthly	200% Annual	Monthly
1	$15,650	$1,304	$31,300	$2,608
2	$21,150	$1,763	$42,300	$3,525
3	$26,650	$2,221	$53,300	$4,442
4	$32,150	$2,679	$64,300	$5,358
5	$37,650	$3,138	$75,300	$6,275
6	$43,150	$3,596	$86,300	$7,192
7	$48,650	$4,054	$97,300	$8,108
8	$54,150	$4,513	$108,300	$9,025
For each addtional person, add	$5,500	$458	$11,000	$917

* 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

- 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 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.

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