

# Medicare Supplemental Coverage Enrollment Form



Underwritten by BlueCross  
BlueShield Kansas Solutions

with Health Statement (Select Option)

Complete this form to apply for enrollment in Medicare Supplement Coverage from BlueCross BlueShield Kansas Solutions. All sections must be completed unless otherwise stated. Once accurately completed, sign and date your enrollment form where indicated and mail it to us in the enclosed postage-paid envelope.

## Section 1 – Applicant Information

Please use the name listed on your Medicare card.

\_\_\_\_\_  
First Name MI Social Security Number E-mail Address

\_\_\_\_\_  
Last Name Suffix (\_\_\_\_) \_\_\_\_ - \_\_\_\_ Home Phone Number (\_\_\_\_) \_\_\_\_ - \_\_\_\_ Cell Phone Number

\_\_\_\_\_  
Residential Address  
\_\_\_\_\_  
City Do you live in the same household as another BlueCross BlueShield Kansas Solutions or Blue Cross and Blue Shield of Kansas Medicare Supplement policyholder?  Yes  No

\_\_\_\_\_  
State ZIP Code +4 County If yes, provide household member's name and Medicare Supplement ID number:

\_\_\_\_\_  
Mailing Address (if different from residential address) Name

\_\_\_\_\_  
City ID Number

\_\_\_\_\_  
State ZIP Code +4 Gender  Male  Female \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Date of Birth Have you used any products containing nicotine (including e-cigarettes, vaping and nicotine patches) within the last 12 months?  Yes  No

## Section 2 – Plan Selection and Effective Date

Select which plan you are requesting:

- |                                 |  |                                  |                      |  |  |
|---------------------------------|--|----------------------------------|----------------------|--|--|
| <input type="checkbox"/> Plan A | <input type="checkbox"/> Plan C*       | <input type="checkbox"/> Plan F* | <b>SELECT PLANS:</b> | <input type="checkbox"/> Plan C Select** | <input type="checkbox"/> Plan F Select** |
| <input type="checkbox"/> Plan G | <input type="checkbox"/> Plan G (HDHP) | <input type="checkbox"/> Plan K  |                      | <input type="checkbox"/> Plan G Select** | <input type="checkbox"/> Plan K Select** |
| <input type="checkbox"/> Plan L | <input type="checkbox"/> Plan N        |                                  |                      | <input type="checkbox"/> Plan N Select** |  |

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Desired Start Date for Coverage

**\*Plan C, Plan C Select, Plan F and Plan F Select are only available if you were first eligible for Medicare before 2020.**

**\*\* If you requested a Select Plan, read the following statement and sign below.**  
I have received and fully understand the information in the enclosed Outline of Coverage and the Select Network Service Area Map explaining the hospital network limitations with Select Benefit Plans. I understand if I choose to obtain inpatient hospital services from a hospital outside my hospital network service area, I may be responsible for applicable deductibles and insurance payments.

### Signature required

\_\_\_\_\_  
Signature of Applicant or Authorized Representative \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Date Signed

**Section 3 – Dental Options (you may only select one)**

I would like to enroll in BlueCare DentalPlus.  Yes  No \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
I would like to enroll in BlueCare DentalPlus PPO.  Yes  No Effective Date  
I would like to enroll in BlueCare DentalPreventive.  Yes  No

**Waiting Period:** There is a 12-month waiting period from the effective date for the following services:

- Crowns, onlays and oral surgery • Dentures and bridges • Dental implants

The waiting period is waived if you were covered under another policy that covered major services and had at least 12 months of continuous major service coverage under that plan (credit will be given for less than 12 months). Waiting periods must be satisfied if there has been a lapse in coverage. Your previous coverage will be verified.

You may be eligible to receive credit towards this waiting period by submitting proof of coverage from your prior dental insurance carrier. Proof of coverage should include the following:

- Letter from dental carrier on their company letterhead
- List of major dental services covered by your policy
- Effective date and termination date

You may send this proof of coverage via email to **membership@bcbsks.com** or by post mail to PO Box 239, Topeka, KS 66601 within 60 days of your dental effective date with us.

**Section 4 – Secure Options**

I would like to enroll in Secure 300 Cancer Plan.  Yes  No  
I would like to enroll in Secure Hospital Indemnity Plan.  Yes  No  
Do you have health insurance coverage as an individual?  Yes  No  
Are you presently covered by Blue Cross and Blue Shield of Kansas?  Yes  No

\_\_\_\_\_  
If yes, provide ID Number \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Requested Effective Date

\_\_\_\_\_  
Group Number (if applicable)

**Your effective date must not be more than 6 months from today.**

**If applying for Secure 300 Cancer Plan:**

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

**Section 4A – Secure Coverage Authorization**

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

- **Applicable to Secure 300 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 800-432-0216.

**Signature required**

\_\_\_\_\_  
Signature of Applicant or Authorized Representative \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Date Signed

Medicare Supplemental Insurance is provided by BlueCross BlueShield Kansas Solutions, a wholly owned subsidiary of Blue Cross and Blue Shield of Kansas. Blue Cross and Blue Shield of Kansas and BlueCross BlueShield Kansas Solutions are independent licensees of the Blue Cross Blue Shield Association. Not connected with or endorsed by the U.S. Government or the Federal Medicare Program.

**Section 5 – Proxy Statement for Dental and/or Secure Coverage**

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 10 days prior to any meeting. I may also revoke my proxy by attending and voting in person at any annual meeting.

Yes  No

Disclaimer: BlueCare DentalPlus and Secure Coverage are provided by Blue Cross and Blue Shield of Kansas.

**Signature required**

\_\_\_\_\_  
Signature of Applicant or Authorized Representative

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Date Signed

**Section 6 – Payment Selection**

Choose your payment option (**mark only one**):

- Please bill me at home** (monthly billing).  
– OR –
- Please automatically draft my financial institution on a monthly basis.** Your next payment will be deducted from your account on or after the 28th of the month preceding coverage.

Financial Institution information (only complete if you selected automatic draft):

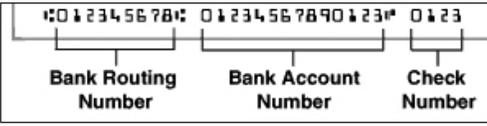
\_\_\_\_\_  
Institution Name

Please deduct from:  Checking  Savings

\_\_\_\_\_  
Routing Number

\_\_\_\_\_  
Account Number

\_\_\_\_\_  
Name of Authorized Signer



By signing, I authorize BlueCross BlueShield Kansas Solutions, an independent licensee of the Blue Cross Blue Shield Association, to send my premium bill to the above-named financial institution for direct payment to my account. By checking this box, I attest that I am the account holder or have been authorized to use the account above. Further, in making this authorization, I agree that each monthly payment shall be the same as if it were an instrument personally signed by me. This authority is to remain in effect until revoked by me in writing. Should any draft entry be dishonored for any reason, or drawn after depositor's authorization has been withdrawn, BlueCross BlueShield Kansas Solutions agrees that the financial institution shall be relieved of any liability.

**Signature required**

\_\_\_\_\_  
Signature of Applicant or Authorized Representative

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Date Signed

\_\_\_\_\_  
Print Name

**Section 7 – Medicare Information**

Please refer to your Medicare Card to complete this section.

Check box if you have **not** received your Medicare card and will call when you receive it.

\_\_\_\_\_  
First Name

\_\_\_\_\_  
Last Name

\_\_\_\_\_  
MI

\_\_\_\_\_  
Medicare Number

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Hospital (Part A) Start Date

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Medical (Part B) Start Date

Note: You must have both Medicare Parts A and B as of your desired Medicare Supplement effective date for coverage to be issued.

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## Section 8 – Coverage Information

1. Did you turn age 65 in the last 6 months?  Yes  No
2. Did you enroll in Medicare Part B in the last 6 months?  Yes  No  
If yes, what is the effective date? \_\_\_\_ / \_\_\_\_ / \_\_\_\_
3. Are you covered for medical assistance through the state Medicaid program?  Yes  No  
Note: If you are participating in a "Spend-Down Program" and have not met your "Share of Cost", please answer NO to this question.  
If yes:  
a. Please mark which type of benefits you have:  
 SLMB – Specified Low-Income Medicare Beneficiary (Medicaid pays your Part B premium only)  
 QMB – Qualified Medicare Beneficiary (you have a Medicaid medical card)
- b. Will you be involuntarily losing Medicaid coverage?  Yes  No  
Note: Proof of loss will be required such as a letter from the Department of Children and Family Services.  
If yes, what is the date Medicaid coverage will end? \_\_\_\_ / \_\_\_\_ / \_\_\_\_
4. Have you had coverage from any Medicare plan other than original Medicare within the past 63 days (for example, a Medicare Advantage plan or a Medicare HMO or PPO)?  Yes  No  
**Not an employer, union or individual plan.**  Yes  No  
If yes:  
a. Please enter your start and end dates. (If you are still covered under this plan, leave end date blank.)  
Start date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ End date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_
- b. Was this your first time to be enrolled in a Medicare Advantage plan or Medicare HMO or PPO?  Yes  No
- c. If you are still covered under the Medicare plan or Medicare HMO or PPO, do you intend to replace your current coverage with this new Medicare Supplement policy?  Yes  No
- d. Did you drop a Medicare Supplement policy to enroll in the Medicare Advantage plan or Medicare HMO or PPO?  Yes  No
- e. Did you lose coverage due to leaving the plan's service area?  Yes  No
5. Do you have another Medicare Supplement policy in effect?  Yes  No  
If yes, do you intend to replace your current Medicare Supplement policy with this policy? Note: You cannot have two Medicare Supplement policies at one time.  Yes  No
6. Have you had coverage under any other health insurance within the past 63 days (for example, an employer, union or individual plan)?  Yes  No  
If yes:  
a. Is this an employer sponsored plan?  Yes  No  
b. Is this plan with Blue Cross and Blue Shield of Kansas?  Yes  No  
If yes, provide Blue Cross ID number: \_\_\_\_\_ Group number: \_\_\_\_\_  
If no, provide name of company: \_\_\_\_\_  
Location of company: \_\_\_\_\_ Type of policy: \_\_\_\_\_
- c. What are the dates of coverage under this policy? (If you are still covered under this plan, leave end date blank.)  
Start date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ End date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

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**Section 9 – Information You Should Know**

- 1. You do not need more than one Medicare supplement policy. Before you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverages.
- 2. You may be eligible for benefits under Medicaid and may not need a Medicare Supplement policy.
- 3. If, after purchasing this policy, you become eligible for Medicaid, the benefits and premiums under your Medicare supplement policy can be suspended, if requested, during your entitlement to benefits under Medicaid for 24 months. You must request this suspension within 90 days of becoming eligible for Medicaid. If you are no longer entitled to Medicaid, your suspended Medicare supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstated if requested within 90 days of losing Medicaid eligibility. If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstated policy will not have outpatient prescription drug coverage but will otherwise be substantially equivalent to your coverage before the date of the suspension.
- 4. Counseling services may be available in your state to provide advice concerning your purchase of Medicare supplement insurance and concerning medical assistance through the state Medicaid program, including benefits as a Qualified Medicare Beneficiary (QMB) and a Specified Low-income Medicare Beneficiary (SLMB).
- 5. If you are eligible for, and have enrolled in, a Medicare supplement policy by reason of disability and you later become covered by an employer or union-based group

health plan, the benefits and premiums under your Medicare supplement policy can be suspended, if requested, while you are covered under the employer or union-based group health plan. If you suspend your Medicare supplement policy under these circumstances, and later lose your employer or union-based group health plan, your suspended Medicare supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstated if requested within 90 days of losing your employer or union-based group health plan. If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstated policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.

- 6. If you intend to cancel existing Medicare supplement insurance and replace it with a policy issued by BlueCross BlueShield Kansas Solutions, you will have 30 days to review your new policy. During this 30-day time period you may decide, without cost, whether you want to keep the policy. Review your new policy carefully and compare it with any accident and sickness coverage you have now. If, after you've reviewed all your policies, you decide to keep this Medicare supplement policy, you should cancel your present Medicare supplement coverage.
- 7. BlueCross BlueShield Kansas Solutions is not connected with or endorsed by the U.S. Government or the Federal Medicare Program.

**Section 10 – Authorization**

*Releases Medicare Claims information to BlueCross BlueShield Kansas Solutions for faster claims processing.*

I hereby authorize the Centers for Medicare and Medicaid Services to furnish BlueCross BlueShield Kansas Solutions, medical or other information required by it or others under the Title XVIII program or Title XIX

state program to the extent necessary to process any claim under the agreement in effect with BlueCross BlueShield Kansas Solutions. I understand that if I should decide to rescind this authorization, some records could be released before the rescission has had time to take effect.

**Signature required**

\_\_\_\_\_  
Signature of Applicant or Authorized Representative

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Date Signed

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## Section 11 – Health Statement

This section does not need to be completed if you are in your Initial Enrollment Period or are a Guaranteed Issue applicant.

**Initial Enrollment:** If you turned 65 in the last six months or if you became eligible for Medicare by reason of disability or End Stage Renal Disease (ESRD) in the last six months, are covered by Medicare Part A and have enrolled in Medicare Part B in the last six months.

**Guaranteed Issue:** If you lost or are losing your health insurance coverage and received a notice from your prior insurer indicating you were eligible for guaranteed issue of a Medicare Supplement policy, or you had certain rights to buy such a policy. **Please include a copy of the notice from your prior insurer with your application.**

All other applicants must complete this section.

1. Please provide your height and weight: Height \_\_\_\_ ft. \_\_\_\_ in. Weight \_\_\_\_\_ lbs.
  
2. During the **last two years**, have you been hospitalized overnight?  Yes  No  
If yes, please include details of the hospitalization(s) in question 7 of the Health Statement below.
  
3. Do you currently have a medical condition that requires you to spend more than **12 hours per day** in bed?  Yes  No  
If yes, please include details of the condition in question 7 of the Health Statement below.
  
4. Do you currently have a medical condition that required **ongoing** use of oxygen?  Yes  No  
If yes, please include details of the condition in question 7 of the Health Statement below.
  
5. In the **last five years**, have you been advised by a physician to have a procedure/surgery for any condition?  Yes  No  
If yes, please include details of the procedure/surgery in question 7 of the Health Statement below.  
If yes, has the procedure/surgery been performed or addressed?  Yes  No

## Section 11 – Health Statement (continued)

6. Have you been diagnosed/treated (including taking medication) for any of the following conditions listed below? Check all that apply.

### Kidney conditions

- Any kidney failure or insufficiency
- Chronic kidney disease
- Currently receiving dialysis
- End Stage Renal Disease (ESRD)

### Cancers or tumors

- Cancer (excluding non-melanoma skin cancer)
- Malignant tumor or growth

### Liver conditions

- Cirrhosis of the liver

### Lung conditions

- COPD
- Emphysema
- Pulmonary Fibrosis

### Heart, vascular or blood conditions

- Aneurysm
- Angioplasty
- Any heart disease requiring a defibrillator
- Bypass surgery
- Carotid artery stents
- Congestive heart failure
- Coronary/carotid artery blockage
- Heart attack
- Heart disease
- Heart surgery
- Peripheral bypass
- Stroke, Transient Ischemic Attack (TIA) or mini-stroke

### Nervous system conditions

- Alzheimer's Disease or Dementia
- Multiple Sclerosis
- Parkinson's Disease
- Systemic Lupus Erythematosus (SLE)

### Transplants

- Bone marrow
- Organ transplant

### Immune system conditions

- Any immune system disorder

### Psychological/mental conditions

- Bipolar Disorder
- Major depression
- Schizophrenia

### Substance abuse

- Alcohol abuse or alcoholism
- Drug abuse or chemical dependency

### Brain or spinal cord conditions

- Paralysis

### Other

- Hemophilia
- Infusion therapy for any condition

### Diabetes

- Diabetes
- Diabetes with any of the following: circulatory problems, kidney problems or retinopathy





**Section 12 – Authorization to Obtain and Disclose Protected Health Information**

This section does not need to be completed if you are in your Initial Enrollment Period or are a Guaranteed Issue applicant.

\_\_\_\_\_  
Name of Insured \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Street Address

\_\_\_\_\_  
City \_\_\_\_\_  
State \_\_\_\_\_  
ZIP Code \_\_\_\_\_  
+4

I authorize any physician, hospital, pharmacy, pharmacy benefit manager, health insurance plan, consumer reporting agency, or any other entity that possesses any diagnosis, treatment, prescription, medical, or credit and financial information about me to furnish such information to BlueCross BlueShield Kansas Solutions for the purpose of evaluating my eligibility for insurance. This medical or health information may include information on the diagnosis and treatment of mental illness, alcohol, and drug use. This also includes information on the diagnosis, treatment, and testing results related to HIV, AIDS, and sexually transmitted diseases, unless otherwise restricted by state law. Health information obtained will not be re-disclosed without my authorization unless permitted by law, in which case it may not be protected under federal privacy rules. This authorization shall be valid for 24 months from this date and may be revoked by sending written notice to BlueCross BlueShield Kansas Solutions at 1133 SW Topeka Blvd., Topeka, KS 66629-0001, Attention: Underwriting Department cc805B3. Your failure to execute this authorization may result in BlueCross BlueShield Kansas Solutions being unable to collect information relating to you and result in denial of your application for health insurance.

**Your signature required**

\_\_\_\_\_  
Signature of Individual Whose Information is to be Disclosed, or Authorized Representative \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Date Signed

\_\_\_\_\_  
Print Name of Individual or Authorized Representative

**Section 13 – Important Information**

This section does not need to be completed if you are in your Initial Enrollment Period or are a Guaranteed Issue applicant.

*To represent your Health Statement.*

I understand any policy issued to me will be issued in reliance on the information I have provided on this health statement and that my signature verifies that I have read all the information on this form and represents that it is correct and accurate.

I understand that BlueCross BlueShield Kansas Solutions has the right to rescind the policy with all premiums refunded to me, less amounts paid for benefits under the policy for the following conditions:

- 1) If information received from future claims or supporting records within two years after the date the contract becomes effective indicates information provided on the health statement was incorrect, or
- 2) If such information received at any time indicates information provided in the health statement was materially misstated or was fraudulent.

I understand that no representative of BlueCross BlueShield Kansas Solutions has the authority to waive any of the information required on this form, to bind BlueCross BlueShield Kansas Solutions to provide coverage for me, or to waive, alter or amend the provisions of any policy, which may be issued to me.

**Continued on the next page.**

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**Section 13 – Important Information (continued)**

I understand that by signing this health statement, I authorize any licensed health care provider, health care facility, insurance company or any organization or person who has or obtains information concerning me to give it to BlueCross BlueShield Kansas Solutions. This authorization is valid for a period no greater than two years.

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 BlueCross BlueShield Kansas Solutions Underwriting Department at 1-800-432-0216. (A photographic copy of this authorization shall be as valid as the original.)

I understand all coverage is subject to the health information provided on this form remaining

**Signature required**

\_\_\_\_\_  
Signature of Applicant or Authorized Representative

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Date Signed

**Section 14 – Authorization and Attestation**

The information on this enrollment form is correct to the best of my knowledge. I understand that if I intentionally provide false information on this form, I will be disenrolled from the insurance plan. I understand that if I unintentionally failed to provide relevant medical history or information, BlueCross BlueShield Kansas Solutions, in its sole discretion, may terminate or otherwise rerate this application for insurance. I understand that my signature, or the signature of the person legally authorized to act on my behalf, on this application means that I have read and understand the full contents of this application. I understand

that by signing below, I am submitting an application for insurance [or insert name of product if needed], and that, if approved, I will be bound the terms and conditions of this contract of insurance. If signed by an authorized representative (as described above), this signature certifies that:

- This person is authorized under State law to complete this enrollment, and
- Documentation of this authority is available upon request.

**Signature required**

\_\_\_\_\_  
Signature of Applicant or Authorized Representative

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Date Signed

\_\_\_\_\_  
Printed Name of Signee

\_\_\_\_\_  
Relationship, if Not Applicant

**Please insert your signed and completed enrollment form in the enclosed postage-paid envelope and return to BlueCross BlueShield Kansas Solutions.**

**Agent Use Only**

Agent First Name \_\_\_\_\_ MI \_\_\_\_\_ Agent ID Number \_\_\_\_\_ (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  
Phone Number

Agent Last Name \_\_\_\_\_

**Signature required**

\_\_\_\_\_  
Agent

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Date Signed

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