PLAN SPONSOR USE ONLY: BLUE KC GROUP NO. _____ CLASS NO. _____ SUBGROUP NO. _____

Employee Application and Change Form

FOR LEVEL FUNDING ADMINISTRATIVE SERVICES ONLY

Please Complete All Boxes LEGIBLY (Print) IN BLUE OR BLACK INK and Sign.

If application is to be used as a Change Form, please specify event below.

DATE OF EVENT: _____

☐ Birth ☐ Change of Address ☐ Divorce ☐ Marriage ☐ Death ☐ Change of Beneficiary ☐ Adoption/Placement ☐ Loss of Other Group Coverage

I Employee Information Only

1. LAST NAME	FIRST NAME	MIDDLE INITIAL	2. STREET ADDRESS

3. CITY	STATE	ZIP CODE	4. HOME PHONE NO. WORK PHONE NO.

5. E-MAIL ADDRESS	6. Gender ☐ Male ☐ Female	7. BIRTH DATE	8. SOCIAL SECURITY NO.

9. HIRE DATE	10. COMPANY NAME	11. POSITION	12. NO. OF HOURS WORKED PER WEEK

II Family Information - Employee and Employee's Dependents to be Enrolled or Changed (attach sheet if necessary)

CHECK APPROPRIATE BOX	SOCIAL SECURITY NO.	LAST NAME FIRST NAME M.I.	DATE OF BIRTH	GENDER	HEIGHT	WEIGHT	COVERAGE SELECTION
☐ New ☐ Change	EMPLOYEE			☐ Male ☐ Female			☐ Medical ☐ Dental ☐ Vision
☐ New ☐ Change	SPOUSE			☐ Male ☐ Female			☐ Medical ☐ Dental ☐ Vision
☐ New ☐ Change	CHILD			☐ Male ☐ Female			☐ Medical ☐ Dental ☐ Vision
☐ New ☐ Change	CHILD			☐ Male ☐ Female			☐ Medical ☐ Dental ☐ Vision
☐ New ☐ Change	CHILD			☐ Male ☐ Female			☐ Medical ☐ Dental ☐ Vision
☐ New ☐ Change	CHILD			☐ Male ☐ Female			☐ Medical ☐ Dental ☐ Vision

LAST NAME _____ FIRST NAME _____

III Waiver of Coverage Selection

I Decline Coverage For	Due to:
Medical ☐ Self ☐ My Spouse ☐ My Dependent Child(ren)	☐ Existence of Other Group Health Coverage ☐ Existence of Other Individual Health Coverage ☐ Medicare or Medicaid ☐ Other Reason (explain) _____

If you are declining medical coverage for yourself or your dependents (including your spouse) because of other group coverage, you or your dependents may in the future be able to enroll in this Plan, provided that you request enrollment within 31 days after your other group coverage ends. In addition, you may be able to enroll yourself and your dependent(s), provided that you request enrollment within 31 days after a marriage, birth, adoption or placement for adoption. If you decline coverage for yourself or your dependents while Medicaid coverage or coverage under a state children's health insurance program (CHIP) is in effect, you and your dependents may be able to enroll in this plan if you or your dependents lose eligibility for that coverage, provided you request enrollment within 60 days after that coverage ends. If you are declining medical and/or dental coverage for any other reason, or if you fail to complete this form, you may be limited to enrolling only during the annual enrollment period. If you or your dependents become eligible for a state premium assistance subsidy from Medicaid or CHIP with respect to this plan, you and your dependents may be eligible to enroll in this plan, provided you request enrollment within 60 after such eligibility is determined.

IV Medical Coverage Selection

Medical Coverage Type (Select only one.) :

☐ Self ☐ Self + Spouse ☐ Self + Child(ren) ☐ Self + Family ☐ Self + Domestic Partner

I Elect the Following Coverage Please mark one. Options available are based on your Plan Sponsor's selections. Contact your Plan Sponsor for available options. Applies to Missouri residents only: If an EPO product is offered, your Employer must also offer a non-EPO product. EPO product Benefits are limited to services provide by Preferred Providers, except for Emergency Services and certain Mental Health office visits. Services provided by Non-Preferred Providers are not covered, except as specified. Two office visits per year to a Non-Preferred Provider acting within the scope of their license are covered for the diagnosis or assessment of a Mental Illness.

Preferred-Care Blue

Preferred-Care Blue (PPO)

☐ $500(OOPM $1,500)
☐ $1,000(OOPM $2,500)
☐ $1,500(OOPM $4,500)
☐ $2,000
☐ $3,000(OOPM $3,000)
☐ $3,000(OOPM $9,100)
☐ $4,000(OOPM $9,100)
☐ $5,000(OOPM $9,100)
☐ $500(OOPM $3,500)
☐ $1,000(OOPM $4,000)
☐ $1,500(OOPM $6,000)
☐ $2,700
☐ $3,000(OOPM $5,000)
☐ $4,000(OOPM $4,000)
☐ $5,000(OOPM $6,500)

AffordaBlue (PPO)

☐ $5,500

BlueSaver (For use with an HSA)*

☐ $3,200 ☐ $4,000 ☐ $5,000 ☐ $6,500

Personal Blue PPO HRA

☐ $3,000

BlueSelect Plus†

BlueSelect Plus (PPO)†

☐ $1,000
☐ $3,000(OOPM $3,000)
☐ $3,000(OOPM $9,100)
☐ $4,000(OOPM $9,100)
☐ $5,000(OOPM $9,100)
☐ $2,000
☐ $3,000(OOPM $5,000)
☐ $4,000(OOPM $4,000)
☐ $4,000(OOPM $4,000) (EPO)

BlueSelect Plus BlueSaver (For use with an HSA)*†

☐ $3,200 (PPO) ☐ $5,000 (PPO) ☐ $5,000 (EPO)

Spira Care with BlueSelect Plus†

☐ $1,500 (EPO) ☐ $3,500 (OOPM $3,500) (EPO)
☐ $3,500(OOPM $9,100) (EPO) ☐ $5,000 (EPO) ☐ $7,000 (EPO)

Spira Care with BlueSelect Plus BlueSaver (For use with an HSA)*†

☐ $3,200 (EPO)

* High Deductible Health Plan ("HDHP") for use with an HSA. Would you like to set up an HSA with your Plan Sponsor's preferred bank? If Yes, please complete Section VII. ☐ YES ☐ NO

† Must meet zip code requirements to enroll in this plan option.

V Other Health Insurance Carrier (for Coordination of Benefits)

1. On the day the coverage begins, will you or any of your dependents applying for this coverage be covered by other health insurance or Medicare, including continuation of coverage?

☐ YES ☐ NO If yes, answer all questions below. Attach sheet if more than one additional policy will be in force.

COVERAGE TYPE	INSURANCE COMPANY NAME (AREA CODE) PHONE NO.	POLICY NO.
☐ Medical Insurance		

NAME OF INSURED	INSURED'S EMPLOYER NAME	EFFECTIVE DATE	TERMINATION DATE

FAMILY MEMBERS COVERED

1. 2. 3.

2. Are any of your dependent children subject to a divorce decree or court order? ☐ YES ☐ NO

If yes, whose coverage is primary? ☐ Yours ☐ The Other Parent's

3. If you or your dependent(s) have Medicare, include a copy of your Medicare card(s) with this Application.

Do you or your dependent(s) have Medicare? ☐ YES ☐ NO If yes, are you actively working? ☐ YES ☐ NO

Are you retired? ☐ YES ☐ NO If yes, please provide date of retirement:

4. Are you or any of your dependent(s) covered under COBRA or State Continuation? ☐ YES ☐ NO

If yes, please provide the effective date and future termination date of coverage:

Effective Date: Future Termination Date:

LAST NAME _____ FIRST NAME _____

VI(a) All Questions Must be Answered Before Your Application Will be Processed

The federal Genetic Information Nondiscrimination Act prohibits plan sponsors from requesting, requiring, purchasing, or collecting "genetic information" for underwriting purposes. "Genetic information" includes your genetic tests, the genetic tests of your family members, and the manifestation of a disease or disorder in family members not covered by the policy. Genetic information can also include requests for, or receipt of, genetic services, or participation in clinical research which includes genetic services. Do not report genetic information on this form. However, information about manifested diseases or conditions of anyone applying for coverage is not considered genetic information and is to be reported on this form, even if the disease or condition is caused by or associated with genetics.

Please check (✓) appropriate box if you or a dependent applying for coverage ever received in the past five (5) years, medical services from a health care provider for any of the conditions listed below. If checked yes, please explain completely in the additional medical information section below. WITHIN **THE LAST 5 YEARS** HAVE YOU OR ANY DEPENDENTS APPLYING FOR COVERAGE BEEN DIAGNOSED OR TREATED FOR ANY OF THE FOLLOWING CONDITIONS?:

YES	NO		YES	NO		YES	NO	
1. □	□	Bone/Joint/Muscular Disorder/ Joint Replacement	13. □	□	Elevated Cholesterol (Last reading _____ Date _____)	24. □	□	Kidney/Bladder/Urinary Disorder
2. □	□	Arthritis/Gout/Back or Neck Disorder	14. □	□	Diabetes-Hemoglobin A1C (Last reading _____ Date _____)	25. □	□	Liver Disorder/Hepatitis A B C
3. □	□	Fibromyalgia/Chronic Fatigue Syndrome	15. □	□	HIV/AIDS/AIDS Related Complex	26. □	□	Chiropractic Treatment – Number of Visits in Last 12 Months _____
4. □	□	Lupus - Type _____	16. □	□	Abnormal Pap Smear (If yes, submit copies of last 2 pap smear results)	27. □	□	Digestive/Intestinal Disorder
5. □	□	Nervous System/Brain Disorder/ Alzheimer's	17. □	□	Infertility/Reproductive Disorder	28. □	□	Crohn's Disease/Diverticulitis/ Diverticulosis
6. □	□	Epilepsy/Seizure Disorder	18. □	□	Cancer - Type _____	29. □	□	Mental/Nervous Disorders
7. □	□	Multiple Sclerosis	19. □	□	Tumor/Cyst/Polyp	30. □	□	Schizophrenia/Manic-Depression/ Suicide Attempt
8. □	□	Parkinson's Disease	20. □	□	Respiratory/Lung Disorder/Asthma/ Tuberculosis	31. □	□	Attention Deficit Disorder
9. □	□	Heart/Circulatory Disorder	21. □	□	Emphysema/Chronic Obstructive Pulmonary Disease	32. □	□	Anorexia/Bulemia
10. □	□	Stroke	22. □	□	Pancreatic Disorder	33. □	□	Any Other Abnormality/Deformity/ Birth Defect (List all below)
11. □	□	High Blood Pressure (Last reading _____ Date _____)	23. □	□	Thyroid Disorder/Goiter	34. □	□	Glaucoma-Eye Pressure Readings R _____ L _____
12. □	□	Blood Disorder/Leukemia/				35. □	□	Eye Disorders/Cataracts

36. PLEASE LIST ANY OTHER CONDITION(S), DIAGNOSED OR TREATED IN THE LAST 5 YEARS, NOT MENTIONED ABOVE: _____

_____

_____

_____

VI(b) Additional Medical Information - List below full details to questions answered in Section VII(a) (attach sheet if necessary)

QUESTION NO.	PERSON TREATED	CONDITION & TYPE OF TREATMENT	DATE OCCURRED	LAST DATE OF TREATMENT	CURRENT STATUS	COMPLETE NAME AND ADDRESS OF PROVIDER

LAST NAME _____ FIRST NAME _____

VI(c) Employee and Family Information - Employee and Employee's Dependents to be Enrolled (attach sheet if necessary)

Please check appropriate box to answer the following questions. If the Yes box is checked, please explain completely and in detail.

A. Are you or any family member or dependent currently pregnant? (Including any dependent not applying for coverage?) ☐YES ☐NO
If yes, Name(s)_____Due Date(s):_____

B. Within the past 12 months have you or any dependents been a patient in the hospital? ☐YES ☐NO
If yes, who_____Numbr of hospital admissions_____
Length of stays_____Reason for hospitalizations_____

C. Within the past 12 months have you or any dependents been advised to have surgery, treatments, tests or studies NOT YET PERFORMED?
☐YES ☐NO
If yes, Name(s)_____
Type of test, surgery, treatment or study_____
Date performed or scheduled_____

D. Within the past 12 months have you or any dependents received Emergency Room Care? ☐YES ☐NO
If yes, Name(s)_____
Number of ER visits in past 12 months_____
Reason(s) for visit(s)_____

E. Have you or any of your dependents consulted a physician, psychiatrist, psychologist, social worker, chiropractor, nurse practitioner, physical, occupational or speech therapist or any other health care professional for any reason, including an annual physical in the last 5 years?
☐YES ☐NO
If yes, please explain_____

F. Has any family member had individual or group counseling in the last 12 months? ☐YES ☐ NO
If yes, Names(s)_____
Frequency of Counseling_____
Date of last counseling session_____

G. Have you or any of your dependents ever had or been advised to have an organ transplant of any type in the last 5 years? ☐YES ☐NO
If yes, Name(s)_____Type_____

H. Have you or any of your dependents ever used or been treated or counseled due to use of the following in the last 5 years:
a) Use of alcohol, sedatives, hallucinogens, illegal substances, narcotics or any other drugs, other than those prescribed by a physician?
☐YES ☐NO
b) If Yes to any items in (a), please indicate types of use, treatment and dates. Date of last use?_____
Date and Type of Treatment:_____
c) Been convicted of a DUI in the last 5 years? ☐YES ☐NO If yes, Date(s)_____

I. Within the last 5 years, have you or any of your dependents used tobacco products, including cigarettes, cigars, pipes, or chewing tobacco?
☐YES ☐NO
If yes, Name(s)_____For how long?_____
How much used daily?_____If no longer using tobacco products, when did you/dependent(s) quit?_____

J. Are any dependents disabled? ☐YES (Give details on a separate page) ☐NO

K. Please list below all prescription medications taken within the last 12 months by you or any of your dependents.

Prescription Information (attach sheet if necessary)

PERSON TREATED	NAME OF DRUG	DOSAGE	FREQUENCY	CONDITION OR ILLNESS	START DATE	STOP DATE	COMPLETE NAME AND ADDRESS OF PHYSICIAN

L. In the past 2 years, has any person listed on this application discontinued medication without approval of a physician or failed to take medication prescribed by a physician?

☐YES ☐NO Name of Medication_____
Reason prescribed_____
Name of person_____

LAST NAME _____ FIRST NAME _____

Medical Questionnaire Continued (attach sheet if necessary)

ANY ADDITIONAL INFORMATION

LAST NAME _____ FIRST NAME _____

VII If You Are Enrolling in a High Deductible HSA Plan and Plan to Establish an HSA With Your Plan Sponsor's Preferred Banking Institution, Please Complete the Following:

EMPLOYEE'S SOCIAL SECURITY NUMBER (UNDER FEDERAL RULES, YOUR SOCIAL SECURITY NUMBER IS REQUIRED TO ESTABLISH AN HSA)

PHYSICAL ADDRESS (IF YOU PROVIDED A POST OFFICE BOX IN SECTION I, A PHYSICAL ADDRESS IS REQUIRED UNDER FEDERAL RULES TO ESTABLISH AN HSA. AN HSA WILL NOT BE OPENED IF ONLY A POST OFFICE BOX IS PROVIDED.

VIII Agreement and Acknowledgement

I request coverage under the health plan(s) ("Plans") offered by my Plan Sponsor and administered by Blue Cross and Blue Shield of Kansas City and Subsidiaries (collectively, "Blue KC") as may from time to time be amended. I authorize my Employer to deduct from my earnings any required contributions.

I understand services will be available subject to the exclusions, limitations, and benefits described in the Plan. I understand that if at any time it is determined by my Plan Sponsor that a person listed on this application did not meet the Plan's definition of dependent, my Plan Sponsor has the right to terminate or rescind coverage for that person or for all ineligible persons under the application, and to recover any benefit payments made for such ineligible person or persons. Furthermore, I understand that if I intentionally misrepresented any of the information on the application, my Plan Sponsor has the right to terminate or rescind coverage for that person or for all persons under the application; however no statement I make voids my coverage unless my statements are material to the risk assumed and contained in my written application. I understand that my medical records will be maintained with strict confidentiality by Blue KC as administrator in accordance with applicable federal and state laws.

If electing a High Deductible Health Plan ("HDHP") Plan, I acknowledge that the HDHP may be for use with a Health Savings Account ("HSA").

EMPLOYEE'S SIGNATURE: _____

PRINTED NAME: _____

DATE: _____

Notices

NOTICE OF WOMEN'S HEALTH AND CANCER RIGHTS ACT:

Along with benefits detailed in your Certificate of Coverage and Schedule of Benefits, your benefits include coverage for (1) breast reconstruction in connection with a mastectomy, including reconstruction of the other breast to produce a symmetrical appearance; (2) prosthesis; and (3) treatment of physical complications from all stages of mastectomy, including lymphedemas. This coverage is subject to copayments, coinsurance and deductibles consistent with other benefits under your plan. This notice is being provided in accordance with the Women's Health and Cancer Rights Act of 1998, a federal law.

SUMMARY OF BENEFITS AND COVERAGE NOTICE:

If you would like a copy of the Summary of Benefits and Coverage (SBC) for the coverage you are applying for, please see your Plan Sponsor for a copy. The SBC is available free of charge. The information in the SBC is subject to change prior to your effective date.