EMPLOYER USE ONLY: BLUE KC GROUP NO. _____ CLASS NO. _____ SUBGROUP NO. _____

Kansas City

An Independent Licensee of the Blue Cross and Blue Shield Association

Employee Application and Change Form

BlueKC.com • One Pershing Square, 2301 Main, P.O. Box 419169, Kansas City, MO 64141-6169 • 816-395-2222

GROUPS WITH 51-99 EMPLOYEES

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

Preferred-Care Blue PPO | BlueSelect Plus

If application is to be used as a Change Form, please specify event below.
DATE OF EVENT: _____ PROPOSED EFFECTIVE DATE: _____

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

I Employee Information Only

1. LAST NAME	FIRST NAME	M.I.	2. STREET ADDRESS

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

5. GENDER ☐ Male ☐ Female	6. SOCIAL SECURITY NO.	7. BIRTH DATE	8. EMPLOYER

9. POSITION	10. HIRE DATE	11. HOURS WORKED PER WEEK	12. PAY FREQUENCY ☐ Weekly ☐ Biweekly ☐ Semi-Monthly ☐ Monthly

13. E-MAIL ADDRESS *Blue KC may use this e-mail address to provide documents, materials, and other notices related to this coverage.*

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	INDICATE COVERAGE
☐ 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
Dental	☐ Self	☐ My Spouse	☐ My Dependent Child(ren)	☐ Medicare or Medicaid
Vision	☐ Self	☐ My Spouse	☐ My Dependent Child(ren)	☐ Existence of Other Individual Health Coverage
				☐ 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. If you decline the USAble Life coverage and elect to enroll for coverage at a later date, you may be required to submit, at your own expense, evidence of insurability to USAble Life. To request a special enrollment for medical and/or dental coverage, please contact our Member Services Department at (816) 395-2950.

IV Medical Coverage Selection

I Elect The Following Coverage Select only one available Product. Product availability is limited to your Employer's selections. *Applies to Missouri residents only:* If an Exclusive Provider Organization (EPO) product is offered, your Employer must also offer a non-EPO product. EPO product Benefits are limited to services provided by Preferred Providers, except for Emergency Services and certain Mental Health office visits. Services provided by Non-Preferred Providers are not covered, except as specifically provided under the product certificate. Covered Services for certain Mental Health office visits include 2 office visits per Calendar Year for the diagnosis or assessment of Mental Illness to a Non-Preferred Provider acting within the scope of their license. The products offered below are underwritten and issued by **Blue Cross and Blue Shield of Kansas City**.

Medical Coverage Type (Select only one.) :

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

Preferred-Care Blue

Preferred-Care Blue (PPO)

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

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

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)

* An HSA will be established unless you indicate otherwise. Please complete section VIII.
☐ No, I do not want to open an HSA
† Must meet zip code requirements to enroll in this plan option.

V Ancillary Coverage Selection

1. Dental and/or Vision Coverage Type If desired, select only one coverage group. Products are limited to your Employer's selections. If your Employer has elected to offer buy-up plans, select either base plan or buy-up plan for the product offered. If no selection is made, the base plan will be the default plan chosen. Selecting a buy-up option may increase your premium.

Dental: ☐ Self ☐ Self + Spouse ☐ Self + Child(ren) ☐ Self + Family ☐ Self + Domestic Partner ☐ Base ☐ Buy-up

Vision: ☐ Self ☐ Self + Spouse ☐ Self + Child(ren) ☐ Self + Family ☐ Self + Domestic Partner ☐ Base ☐ Buy-up

2. Life Coverage Information Life coverage is available only for Employees who work an average of 25 hours a week or more. If Life coverage is desired, select "Yes." Product availability is limited to your Employer's selections. Employer may or may not be providing all premium contribution amounts for Life coverage. If you decline USAble Life coverage and elect to enroll for coverage at a later date, you may be required to submit, at your own expense, evidence of insurability to USAble Life.

☐ Yes (I understand that selecting this option may require premium contributions for Life coverage on my part.)
Are your annual Employee earnings $30,000 or more? ☐ Yes ☐ No (May affect eligibility for maximum distribution amounts under certain Life products chosen by your Employer.)

☐ No. (I choose to waive all Life coverage and do not want to make premium contributions for Life coverage if Employer is not providing the full premium contribution amount.)

LAST NAME _____ FIRST NAME _____

VI 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		

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:

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

The federal Genetic Information Nondiscrimination Act prohibits health insurers 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	
1.	☐	☐	Bone/Joint/Muscular Disorder/ Joint Replacement
2.	☐	☐	Arthritis/Gout/Back or Neck Disorder
3.	☐	☐	Fibromyalgia/Chronic Fatigue Syndrome
4.	☐	☐	Lupus - Type _____
5.	☐	☐	Nervous System/Brain Disorder/ Alzheimer's
6.	☐	☐	Epilepsy/Seizure Disorder
7.	☐	☐	Multiple Sclerosis
8.	☐	☐	Parkinson's Disease
9.	☐	☐	Heart/Circulatory Disorder
10.	☐	☐	Stroke
11.	☐	☐	High Blood Pressure (Last reading _____ Date _____)
12.	☐	☐	Blood Disorder/Leukemia/ Hemophilia
13.	☐	☐	Elevated Cholesterol (Last reading _____ Date _____)
14.	☐	☐	Diabetes-Hemoglobin A1C (Last reading _____ Date _____)
15.	☐	☐	HIV/AIDS/AIDS Related Complex
16.	☐	☐	Abnormal Pap Smear (If yes, submit copies of last 2 pap smear results)
17.	☐	☐	Infertility/Reproductive Disorder
18.	☐	☐	Cancer - Type _____
19.	☐	☐	Tumor/Cyst/Polyp
20.	☐	☐	Respiratory/Lung Disorder/Asthma/Tuberculosis
21.	☐	☐	Emphysema/Chronic Obstructive Pulmonary Disease
22.	☐	☐	Pancreatic Disorder
23.	☐	☐	Thyroid Disorder/Goiter
24.	☐	☐	Kidney/Bladder/Urinary Disorder
25.	☐	☐	Liver Disorder/Hepatitis A B C
26.	☐	☐	Chiropractic Treatment – Number of Visits in Last 12 Months _____
27.	☐	☐	Digestive/Intestinal Disorder
28.	☐	☐	Crohn's Disease/Diverticulitis/ Diverticulosis
29.	☐	☐	Mental/Nervous Disorders
30.	☐	☐	Schizophrenia/Manic-Depression/Suicide Attempt
31.	☐	☐	Attention Deficit Disorder
32.	☐	☐	Anorexia/Bulemia
33.	☐	☐	Any Other Abnormality/Deformity/ Birth Defect (List all below)
34.	☐	☐	Glaucoma-Eye Pressure Readings R _____ L _____
35.	☐	☐	Eye Disorders/Cataracts

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

_____

LAST NAME _____ FIRST NAME _____

VII(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

VII(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 dependent currently pregnant? (Including any dependent not applying for coverage?) ☐ YES ☐ NO
If yes, Name(s)_____ Due Date(s):_____
Any multiple births anticipated? ☐ YES ☐ NO

B. Within the past 12 months have you or any dependents been a patient in the hospital? ☐ YES ☐ NO
If yes, who _____ Number 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. Have you or any dependent had individual or group counseling the last 12 months? ☐ YES ☐ NO
If yes, Name(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 since 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, on the next page, all prescription medications taken within the last 12 months by you or any of your dependents.

LAST NAME _____ FIRST NAME _____

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
							NAME: ADDRESS:
							NAME: ADDRESS:
							NAME: ADDRESS:
							NAME: ADDRESS:

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 _____

Medical Questionnaire Continued (attach sheet if necessary)

ANY ADDITIONAL INFORMATION

LAST NAME _____ FIRST NAME _____

VIII Agreement and Acknowledgement

I request coverage under the Group Contract(s) ("Contract") issued by Blue Cross and Blue Shield of Kansas City and Good Health HMO, Inc. d/b/a Blue Care Inc. (collectively, "Blue KC") and coverage under the Group Life Policy ("Policy") issued by USAble Life as may from time to time be amended. I authorize my Employer to deduct from my earnings any required contributions. I understand coverage under the Contract and coverage under the Group Life Policy issued by USAble Life will be available subject to the exclusions, limitations and benefits described in, as applicable, the Contract and the Group Life Policy issued by USAble Life and the USAble Life certificate. I authorize any physician, medical practitioner, hospital, clinic, or other medically related facility, insurance or reinsurance company, having information on me or any member of my family (only those who have applied for coverage on this application) regarding our mental and physical health, other insurance coverage, hazardous activities, character, general reputation, finances, and vocation to give to USAble Life, its reinsurers, or its legal representative any and all such information to use for underwriting insurance. I authorize all said sources, to give such records or knowledge to any agency employed by the company to collect and transmit such information in order to facilitate its rapid submission. I agree that this authorization shall be valid for two (2) years from the application date. I agree that a photocopy of this authorization shall be as valid as the original, and I understand that a copy is available to me or my representative upon request. I represent that the statements and answers in this application are true, complete and correctly recorded. I understand that the statements and answers provided by me in this application shall be a basis of any coverage issued and the coverage is conditioned upon its truth.

I understand that if at any time it is determined by Blue KC or USAble Life that a person listed on this application did not meet the Contract's or Policy's definition of dependent, Blue KC and/or USAble Life 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 or fraudulently misrepresented a material fact on the application, made a material misrepresentation of a material fact about any person contained herein, or committed fraud in the process of obtaining the coverage outlined on this application, Blue KC and/or USAble Life have 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. After my coverage has been in force for two (2) years from the effective date, no statement except fraudulent statements I make voids my medical, life, or dental coverage or reduces my benefits. I understand that my medical records will be maintained with strict confidentiality by Blue KC and USAble Life in accordance with applicable federal and state laws.

The translation is for informational purpose only; and the English version will be controlling unless the language in the other language version is shown to be a fraudulent misrepresentation.

La traducción está para el propósito informativo solamente; y la versión inglesa controlará a menos que la lengua en la otraversión de la lengua se demuestre para ser una mala representación fraudulenta.

EMPLOYEE'S SIGNATURE: _____

PRINTED NAME: _____

DATE: _____

LAST NAME _____ FIRST NAME _____

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.

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT NOTICE:

Under the terms of the Newborn and Mother's Health Act of 1996, the Mothers' Health Plan generally may not restrict Covered Services for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than forty-eight (48) hours following vaginal delivery (not including the day of delivery), or less than ninety-six (96) hours following a cesarean section (not including the day of surgery). Nothing in this paragraph prohibits the mother's or newborn's attending Provider, after consulting with the mother, from discharging the mother or her newborn earlier than the specified time frames or from requesting additional time for hospitalization. In any case, the Plan may not require that a Provider obtain authorization from the Plan for prescribing a length of stay not in excess of forty-eight (48) or ninety-six (96) hours, as applicable. However, preauthorization is required to use certain Providers or facilities, or to reduce out-of-pocket costs.

GENETIC INFORMATION NONDISCRIMINATION ACT NOTICE:

Effective January 1, 2010, and notwithstanding anything in the Plan to contrary, the Plan will comply with the Genetic Information Nondiscrimination Act. In general, the Plan cannot set premiums on the basis of genetic information, request or require a participant to undergo a genetic test, or request, require, or purchase genetic information for underwriting purposes or collect genetic information about a participant before the participant is enrolled or covered under the Plan.

SUMMARY OF BENEFITS AND COVERAGE NOTICE:

If you would like a copy of the Summary of Benefits and Coverage (SBC) for the product you are applying for, please see your employer for a copy. The SBC is available free of charge. SBCs are also available electronically at BlueKC.com. The information in the SBC is subject to change prior to your effective date.

NOTICE RELATING TO THE PROTECTION OF RELIGIOUS BELIEFS AND MORAL CONVICTIONS:

Your health plan's coverage does not include an elective pregnancy termination benefit.

DISCRIMINATION IS AGAINST THE LAW

Blue KC complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Blue KC does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Blue KC:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact Customer Service, 816-395-6340 (local), 844-395-7126 (Toll free), languagehelp@bluekc.com.

If you believe that Blue KC has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: the Appeals Department, PO Box 419169, Kansas City, MO 64141-6169, 816-395-3537, TTY: 816-842-5607, appeals@bluekc.com. You can file a grievance in person or by mail, or email. If you need help filing a grievance, the Appeals Department is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-868-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Language Notices

NEED THIS COMMUNICATION IN ANOTHER LANGUAGE?

If you need these services, contact Customer Service, 1-844-395-7126 (Toll free), languagehelp@bluekc.com.

Spanish: Si usted, o alguien a quien usted está ayudando, tiene preguntas acerca de Blue KC, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 1-844-395-7126.

Chinese: 如果您，或是您正在協助的對象，有關於 Blue KC 方面的問題，您 有權利免費以您的母語得到幫助和訊息。洽詢一位翻譯員，請撥電話1-844-395-7126.