Kansas City

An Independent Licensee of the Blue Cross and Blue Shield Association

Individual & Family Plan
Direct Enrollment Application

BlueKC.com • 1400 Baltimore Ave., Kansas City, MO 64105 • 844-515-6311

All Questions Must be Answered. Please Print in Blue or Black Ink.

REQUESTED EFFECTIVE DATE:
[_____ / _____ / _____]

PLEASE CHECK ONE: ☐ New Application ☐ Change (if application is to be used as a Change Form, please specify): ☐ Birth ☐ Death ☐ Marriage ☐ Divorce ☐ Address ☐ Placement/Adoption ☐ Change in Benefits ☐ Loss of Minimum Essential Coverage (except for termination due to non-payment of premiums or termination for cause) ☐ Offered an ICHRA (Individual Coverage HRA) or QSEHRA ☐ Other

(Please call Customer Service at 866-859-3822 (TTY:711)) Date of Event: ____/ _____/ _____

[LIST BILL NUMBER]

I — Applicant Information

1. LAST NAME	FIRST NAME	MIDDLE INITIAL	2. DATE OF BIRTH	3. SOCIAL SECURITY NO.	
4. *HOME ADDRESS (Street Number and Name, Apt. Number)			CITY AND STATE	COUNTY	ZIP CODE
5. *ALTERNATE ADDRESS (Please indicate only one): ☐ Billing Only ☐ Billing and All Correspondence			CITY AND STATE	COUNTY	ZIP CODE

6. DAYTIME PHONE NUMBER	7. E-MAIL ADDRESS Blue Cross and Blue Shield of Kansas City (Blue KC) may use this email address to provide documents, materials and other notices related to coverage.	Race/Ethnicity:
8. HOME PHONE NUMBER		

* Home address denotes applicant's permanent legal residence address and must be completed. Alternate address should be selected if billing, I.D. cards, etc. should go to a different address than the applicant's home address.

II — Medical Coverage Selection — Select type of coverage desired (Individual or Family), and then select only one Product box:

TYPE OF COVERAGE DESIRED: ☐ Individual ☐ Family

Community Preferred Care Blue EPO**	Choice with Spira Care BlueSelect EPO*	Simply Blue with Spira Care Blue Metro EPO***	First Preferred Care Blue EPO**	Catastrophic BlueSelect EPO*	Standard BlueSelect EPO**	Standard Preferred Care Blue EPO**
☐ Silver $6000	☐ Silver 1 $4150 ☐ Bronze 2 $8500	☐ Gold $1700 ☐ Silver $4600 ☐ Bronze $8000	☐ Bronze $7000	☐ Catastrophic $10600	☐ Gold $2000 ☐ Silver $6000 ☐ Bronze $7500	☐ Gold $2000 ☐ Silver $6000 ☐ Bronze $7500

*BlueSelect EPO – Only available if Applicant resides in the following counties: Kansas = Johnson or Wyandotte or Missouri = Clay, Jackson, Johnson, Lafayette, Platte, and Ray.

**Preferred Care Blue EPO – Only available if Applicant resides in the following counties: Missouri = Andrew, Atchison, Bates, Benton, Buchanan, Caldwell, Carroll, Cass, Clinton, DeKalb, Daviess, Gentry, Grundy, Harrison, Henry, Holt, Livingston, Mercer, Nodaway, Pettis, Saline, Saint Clair, Vernon, and Worth.

***Blue Metro EPO – Only available if Applicant resides in the following counties: Kansas = Johnson or Wyandotte or Missouri = Jackson.

Member Information (Please provide again to assist in case pages become separated)

LAST NAME: FIRST NAME: SOCIAL SECURITY NUMBER:

III — Dental Coverage Selection — Complete Pediatric Dental Acknowledgment and if desired, select a Dental Plan.

NOTE: This policy does NOT include embedded Pediatric Dental coverage, which is an Essential Health Benefit (EHB) for dependents under the age of 19.

Section III Dental Coverage is offering Stand Alone Dental Plan (SADP) purchase through Blue KC. In addition, SAPD plans may also be purchased through the Health Insurance Marketplace at Healthcare.gov.

Your acknowledgment of pediatric dental coverage is a requirement by the Affordable Care Act and related regulations.

You understand that you are purchasing coverage for a Blue KC policy that does NOT include pediatric dental and instead have purchased a separate stand-alone dental plan certified by the Exchange or through Blue KC that provides coverage for pediatric dental services.

OR you have no dependents under the age of 19 that require pediatric dental coverage.

By signing, you are attesting that you have read and understand Section III Dental Coverage, as it relates to Pediatric Dental Coverage -

SIGNATURE REQUIRED: _____

Preferred-Care Dental PPO Base Plans	Standard Plan Details	
☐ BlueDental 1000 Preventive (Type I) / Basic (Type II)	Deductible: $50 for Type II Coinsurance: 0% (Type I) / 20% (Type II) Calendar Year Maximum: $1,000	☐ BlueDental Preventative 1000 Deductible: $0 for Type I Preventive (Type I) Coinsurance: 0% Type I Calendar Year Maximum: $1,000
☐ BlueDental Plus 1000 Preventive / Basic / Major (Type III)	Deductible: $50 (Type II) / $200 (Type III) Coinsurance: 0% (Type I) / 20% (Type II) / 50% (Type III) Calendar Year Maximum: $1,000	BlueDental Plus Buy-Up Options: (Check if desired. I understand any election *may increase my premium*.) OR ☐ $1,200 OR ☐ $1,500

☐ YES ☐NO

Have you and/or any person applying for coverage been covered under a previous dental insurance plan? If yes, please provide the following information. Please note: Coverage must be in force for the past 3 - 12 months with no gap in coverage in order to waive any applicable waiting periods for Type 2 services.

Name(s) of individuals covered: _____

Carrier name(s): _____ Policy ID number(s): _____

Effective date(s): _____ Termination date(s): _____

IV — Applicant/Family Information — If more space needed, please use and attach an additional application:

SOCIAL SECURITY NO.	LAST NAME FIRST NAME MIDDLE INITIAL	MEDICAL	DENTAL	DATE OF BIRTH	SEX
APPLICANT		☐	☐		☐MALE ☐FEMALE
SPOUSE		☐	☐		☐MALE ☐FEMALE
DEPENDENT		☐	☐		☐MALE ☐FEMALE
DEPENDENT		☐	☐		☐MALE ☐FEMALE
DEPENDENT		☐	☐		☐MALE ☐FEMALE
DEPENDENT		☐	☐		☐MALE ☐FEMALE

V — General Information

☐ YES	☐NO	1. Have you or any of your dependents ever smoked or used tobacco products, including cigarettes, cigars, pipes, or chewing tobacco on average 2 - 6 or more times per week within the last 4 - 8 months, not including religious or ceremonial use? If yes, name(s) _____
☐ YES	☐NO	2. Are any dependents disabled? (Give details on a separate page)
☐ YES	☐NO	3. Currently or as of the effective date of the Blue KC coverage you are applying for, will you or any of the dependents listed on this application be entitled to[1] or receive premium-free Medicare Part A? If yes, name(s) _____
☐ YES	☐NO	4. Currently or as of the effective date of the Blue KC coverage you are applying for, will you or any of the dependents listed on this application be enrolled in[2] Medicare Premium Part A, Part B, or a Medicare Advantage plan (Part C)? If yes, name(s) _____
☐ YES	☐NO	5. Currently or as of the effective date of the Blue KC coverage you are applying for, will you or any of the dependents listed on this application be eligible for[3] Medicare Premium Part A, Part B, or a Medicare Advantage (Part C) plan? If yes, name(s) _____

1. Entitled to means an individual meets the eligibility requirements and is actually enrolled in the premium-free Medicare Part A. Some individuals who are entitled to premium-free Medicare Part A will be automatically enrolled while others who qualify for premium-free Medicare Part A need to sign up in order to receive those benefits. If you are uncertain as to whether you are entitled to premium-free Medicare Part A, consult www.Medicare.gov.
2. Enrolled in means the individual is both eligible for and has taken the necessary steps to enroll in a Medicare product (Premium Part A, Part B, or a Medicare Advantage plan (Part C)).
3. Eligible for means the individual meets the requirements for an individual to enroll in Medicare Part A, Part B, or a Medicare Advantage (Part C) plan, regardless of whether the individual applies to receive Medicare benefits.

Member Information (Please provide again to assist in case pages become separated)

LAST NAME: FIRST NAME: SOCIAL SECURITY NUMBER:

VI — Agreement

I request coverage under the Direct Enrollment Contract ("Contract") issued by Blue Cross and Blue Shield of Kansas City ("Blue KC"). I understand services will be available subject to the exclusions, limitations, and benefits described in the Contract(s). I understand that Blue KC relies on the truth of my answers and statements and that the Contract is conditioned upon both the truth of the information I have provided herein and, on all matters, disclosed herein remain unchanged until the effective date of the Contract. If any information changes or I become aware of information different from that provided in this application, I agree to provide that additional information promptly to Blue KC. I acknowledge that if I or any dependent is employed, such employer is not contributing toward the cost of this coverage. I understand that any misstatement on this enrollment application or failure to provide additional information about changes prior to the date on which the Contract is issued, may result in a re-rate of the premium or cancellation of coverage. I understand that if at any time it is determined by Blue KC that a person listed on this application did not meet the Contract's definition of dependent, or I misrepresent any of the information contained herein, Blue KC has the right to re-rate coverage. I understand that if I may be guilty of insurance fraud Blue KC has the right to rescind coverage for that person or for all persons under the application, and to recover any benefit payments for such person or persons. I understand that no statement I make will void my coverage or reduce my benefits unless my statements are material to the risk assumed and contained in my written application.

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.

(PARENT OR GUARDIAN SIGNATURE REQUIRED FOR MINORS UNDER THE AGE OF 18.)

Applicant's Signature:

Printed Name:

Date: / /

VII — Broker Representation (if applicable)

I represent that to the best of my knowledge all statements are complete and accurate.

Blue KC Broker Number

/ /

PRINTED BROKER'S NAME BROKER SIGNATURE DATE

REQUIRED

( ) -

TELEPHONE NUMBER E-MAIL ADDRESS

Member Information (Please provide again to assist in case pages become separated)

LAST NAME: FIRST NAME: SOCIAL SECURITY NUMBER:

VIII – Notices

Notice of Women's Health and Cancer Rights Act:
Along with benefits detailed in your Contract 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.

Notice of Summary of Benefits and Coverage:
If you would like a copy of a Summary of Benefits and Coverage (SBC) for the product you are applying for, please visit BlueKC.com. A paper copy is also available, free of charge, by calling 866-859-3822 (TTY:711). 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:
The coverage you have applied for does not include elective pregnancy termination coverage.

If a broker or agent provided services associated with your selection and enrollment of a Blue KC QHP, that broker or agent will receive a direct compensation of $20 per member per month.

Payment Method

Please remember to enclose correct premium payment. Make checks payable to BCBS of KC.

* With Electronic Funds Transfer, your premium is automatically deducted from your checking account every month.
* Your first premium will be processed immediately upon approval.
* Your premium will be paid automatically, on time, each and every month.
* For future payments, your account will be drafted on the 5th of each month or next business day.
☐ Please debit my account automatically each month for the full premium amount due.

Name:	Social Security Number:
Name of Bank:	Name on Account:
Routing Number (9 digits):	Bank Account Number:

☐ Yes, I want Electronic Funds Transfer.

Signature:	Date:

CREDIT CARD AUTHORIZATION: We offer the convenience of paying by credit card. Payment by credit card can be accepted for a payment of one or more premiums; or with your signed authorization, we can automatically charge your credit card for your full premium each month. To pay by credit card, select one of the following options (all information must be complete for processing):

☐ Please charge my credit card automatically each month for the full premium amount due.

* I understand that my credit card will be charged each month on the 5th day of the month or next business day.

Choose only one: ☐ Visa ☐ Master Card

Account Number:	Expiration Date:	CVV Code:
Billing Address:		
Account Name:		
Signature:		

NOTE: To cancel your automatic credit card authorization, your request must be received 10 days prior to your credit card withdrawal date.

FOR AGENT USE ONLY

Agent Full Name:	Agent Number:
Telephone Number:	Email Address:

Address:	City:	State & Zip Code:

Discrimination is Against the Law

Blue Cross and Blue Shield of Kansas City ("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 (including sex characteristics, including intersex traits; pregnancy or related conditions; sexual orientation; gender identity, and sex stereotypes). Blue KC does not exclude people or treat them less favorably because of race, color, national origin, age, disability, or sex.

Blue KC:

- Provides people with disabilities reasonable modifications and free appropriate auxiliary aids and services 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 assistance services to people whose primary language is not English, which may include:
    - Qualified interpreters
    - Information written in other languages.

If you need reasonable modifications, appropriate auxiliary aids and services, or language assistance services, contact ACA/QHP: 1-866-859-3822 (TTY:711), Commercial: 816-395-3558 (local) or 888-989-8842, Medicare Supplemental: 1-888-890-4423 (TTY:711), Medicare Advantage: 1-866-508-7140 (TTY:711), and Medicare Advantage Employer Group Waiver Plan: 1-888-

892-8907 (TTY:711).

Blue KC's Section 1557 Coordinator can be reached by contacting: Section 1557 Coordinator, PO Box 419169, Kansas City, MO 64141-6169, 816-395-3537, TTY: 816-842-5607, APPEALS@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: 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, fax, 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

1-800-368-1019, 800-537-7697 (TDD)

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

This notice is available at Blue KC's website: https://www.bluekc.com/consumer/non-discrimination-information/

If you, or someone you're helping, has questions about Blue KC, you have the right to get help and information in your language at no cost. To talk to an interpreter, call 1-844-395-7126.

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。

Vietnamese: Nếu quý vị, hay người mà quý vị đang giúp đỡ, có câu hỏi về Blue KC, quý vị sẽ có quyền được giúp và có thêm thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, xin gọi 1-844-395-7126.

Cushite: Isin yookan namni biraa isin deeggartan Blue KC irratti gaaffii yo qabaattan, kaffaltii irraa bilisa haala ta'een afaan keessaniin odeeffannoo argachuu fi deeggarsa argachuuf mirga ni qabdu. Nama isiniif ibsu argachuuf, lakkoofsa bilbilaa 1-844-395-7126 tiin bilbilaa.

Korean: 만약 귀하 또는 귀하가 돕고 있는 어떤 사람이 [Blue KC]에 관해서 질문이 있다면 귀하는 그러한 도움과 정보를 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 그렇게 통역사와 얘기하기 위해서는 1-844-395-7126 로 전화하십시오.

Arabic:
إن كان لديك أو لدى شخص تساعده أسئلة بخصوص Blue KC ، فلديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون اية تكلفة. للتحدث مع مترجم اتصل بـ 1-844-395-7126.

French: Si vous, ou quelqu'un que vous êtes en train d'aider, a des questions à propos de Blue KC, vous avez le droit d'obtenir de l'aide et l'information dans votre langue à aucun coût. Pour parler à un interprète, appelez 1-844-395-7126.

Russian: Если у вас или лица, которому вы помогаете, имеются вопросы по поводу Blue KC, то вы имеете право на бесплатное получение помощи и информации на вашем языке. Для разговора с переводчиком позвоните по телефону1-844-395-7126.

German: Falls Sie oder jemand, dem Sie helfen, Fragen zum Blue KC haben, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 1-844-395-7126 an.

Tagalog: Kung ikaw, o ang iyong tinutulangan, ay may mga katanungan tungkol sa Blue KC, may karapatan ka na makakuha ng tulong at impormasyon sa iyong wika ng walang gastos. Upang makausap ang isang tagasalin, tumawag sa1-844-395-7126.

Laotian: ຖ້າຫ ່ານ, ຫ ຼື ຄົນ ່ ໃຫ ່ ານກ ່ າວ ່ ງຊ ່ ວຍຫ ຼື ອ, ມ ່ ີຄ ່ າຖ ່ ານກ ່ ່ ຽວກ ັ ບ Blue KC, ຫ ່ ານມ ີ ສ ິ ດ ່ ໃຫ ່ ລະໄດ ້ ຮ ັ ບການຊ ່ ວຍຫ ຼື ອ ແລະ ່ ຂ ໍ ມ ູ ນຂ ່ າວສານ ່ ໃຫ ້ ເປ ັ ນພ າສ າຂ ອ ງຫ ່ ານ ່ ໂດ ຍ ບ ່ ໍ ເ ສ ັ ຽ ຄ ່ າໃ ຊ ້ ຈ ່ າ ຍ. ການ ໂ ອ ້ ລ ົ ມ ກ ັ ບ ນ າ ຍ ພ າ ສ າ, ໃ ຫ ້ ໂ ທ ຫ າ 1-844-395-7126.

Mon-Khmer: ប្រសិនបើអ្នក ឬនរណាម្នាក់ដែលអ្នកកំពុងជួយមានសំណួរអំពី Blue KC អ្នកមានសិទ្ធិទទួលបានជំនួយ និងព័ត៌មានជាភាសារបស់អ្នកដោយឥតគិតថ្លៃ។ ដើម្បីនិយាយជាមួយអ្នកបកប្រែផ្ទាល់មាត់ម្នាក់ សូមទូរសព្ទទៅលេខ 1-844-395-7126.

Persian:
اگر شما، یا کسی که شما به او کمک میکنید ، سوال در مورد Blue KC ، داشته باشید حق این را دارید که کمکو اطلاعات به زبان خود را به طور رایگان دریافت نمایید 1-844-395-7126.شماس حاصل نمایید.

Hmong: Yog hais tias koj, los sis ib tus neeg twg uas koj tab tom pab, muaj lus nug txog Blue KC, koj muaj cai tau txais kev pab thiab cov ntaub ntawv sau ua koj hom lus yam tsis xam tus nqi dab tsi li. Yog xav tham nrog ib tus neeg pab txhais lus, hu rau 1-844-395-7126.

Portuguese: Se você, ou alguém a quem você está ajudando, tem perguntas sobre o Blue KC, você tem o direito de obter ajuda e informação em seu idioma e sem custos. Para falar com um intérprete, ligue para 1-844-395-7126.

For TTY services, please call **1-816-842-5607**.