Kansas City

An Independent Licensee of the Blue Cross and Blue Shield Association

Direct Enrollment Application

BlueKC.com • One Pershing Square, 2301 Main, P.O. Box 419169, Kansas City, MO 64141-6169 • 816-395-2222 | 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 ☐ Coverage obtained due to court order ☐ Eligibility change for Advanced Premium Tax Credit or Cost-Sharing Reduction ☐ End of non-calendar year policy ☐ Loss of Minimum Essential Coverage (except for termination due to non-payment of premiums or termination for cause) ☐ Other

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.				
8. HOME PHONE NUMBER					

* Home address denotes applicant's permanent legal 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	Choice Spira Care BlueSelect	Choice Spira Care BlueSelect Plus	SAVER BlueSelect	SAVER Preferred-Care Blue	FIRST Preferred-Care Blue	Standard BlueSelect	Standard Preferred-Care Blue	Catastrophic BlueSelect
☐ Silver 6000**	☐ Silver 5000*	☐ Silver 5000*	☐ Bronze 6500*	☐ Bronze 6500	☐ Bronze 7000 **	☐ Silver 5800 5800*	☐ Gold 2000	☐ Catastrophic 9100*
	☐ Silver 6000*	☐ Bronze 7000*				☐ Bronze 7500*	☐ Silver 5800**	
	☐ Bronze 7000*						☐ Bronze 7500**	
	☐ Bronze 8700*							

*Notates products are only available if Applicant resides in Wyandotte or Johnson counties in Kansas, or Clay, Jackson, Platte, Johnson, Lafayette, or Ray counties in Missouri.

**Notates products ARE NOT available if applicant resides in Wyandotte or Johnson counties in Kansas, or Clay, Jackson, Platte, Johnson, Lafayette, or Ray counties in Missouri.

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

LAST NAME: FIRST NAME: SOCIAL SECURITY NUMBER:

III — Dental Coverage Selection — If desired, check one Preferred-Care Dental PPO Base Plan.

Preferred-Care Dental PPO Base Plans (Check one.)	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 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

☐ 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 6 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

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

LAST NAME: FIRST NAME: SOCIAL SECURITY NUMBER:

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 4 or more times per week within the last 6 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 receiving 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.

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 misrepresented any of the information contained herein, Blue KC has the right to re-rate coverage. I understand that if at any time it is determined by Blue KC that I committed an act, practice, or omission that constitutes fraud or that I intentionally made a material misrepresentation of a material fact about any person contained herein, 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.

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

Applicant's Signature:

Printed Name:

Date:

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

LAST NAME: FIRST NAME: SOCIAL SECURITY NUMBER:

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

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 1-877-410-6716. 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 NO:

NAME OF BANK NAME ON ACCOUNT

ROUTING NUMBER (9 digit #) BANK ACCOUNT #

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's Full Name	Agent #	Telephone #
Address	City	State Zip
E-Mail Address		

Blue Cross and Blue Shield of Kansas City 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:

- 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, 844-395-7126 (Toll free), languagehelp@bluekc.com.