Kansas City

An Independent Licensee of the Blue Cross and Blue Shield Association

Individual & Family Plan
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 ☐ Change in Benefits ☐ Loss of Minimum Essential Coverage (except for termination due to non-payment of premiums or termination for cause) ☐ 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 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	Choice Spira Care		Saver	FIRST	Catastrophic	Standard	
Preferred Care Blue**	BlueSelect*	BlueSelect Plus*	Preferred Care Blue	Preferred Care Blue**	BlueSelect*	BlueSelect*	Preferred Care Blue
☐ Silver $6000	☐ Silver 1 $5000 ☐ Silver 2 $6000 ☐ Bronze 1 $7000 ☐ Bronze 2 $8700	☐ Silver $5000 ☐ Bronze $7000	☐ Bronze $6500	☐ Bronze $7000	☐ Catastrophic $9450	☐ Silver $5900 ☐ Bronze $7500	☐ Gold $1500 ☐ Silver $5900 ** ☐ Bronze $7500 **

*BlueSelect & BlueSelect Plus - 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 are NOT available if Applicant resides in the following counties: Kansas = Johnson or Wyandotte or Missouri = Clay, Jackson, Johnson, Lafayette, Platte, and Ray.

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. Check Buy-Up Option(s) if also desired:

☐ YES	☐ NO	Please check YES or NO: I have purchased a separate stand-alone dental plan certified by the Exchange that provides coverage for pediatric dental services as required by the Affordable Care Act and related regulations, and I do not wish to purchase pediatric dental coverage as a part of my BlueKC coverage. (If YES, please provide documentation of separate stand-alone dental plan purchase and Exchange certification.)

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 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

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 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 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 I may be guilty of insurance fraud as determined by a court of law, 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: / /

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 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.

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.

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:
Rounting 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: