Kansas City

An Independent Licensee of the Blue Cross and Blue Shield Association

Short-Term Security Application

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

REQUESTED EFFECTIVE DATE: _____

You may request an Effective Date of the 1st of the month from the application date up to 60 days in advance

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)			
5. CITY	6. STATE	7. ZIP	8. COUNTY
9. *ALTERNATE ADDRESS (Please indicate only one): ☐ Billing Only ☐ Billing and All Correspondence			
10. CITY	11. STATE	12. ZIP	13. COUNTY

14. DAYTIME PHONE NO.	15. HOME PHONE NO.	16. 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.

* 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.

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

	SOCIAL SECURITY NO.	LAST NAME	FIRST NAME	M.I.	GENDER	DATE OF BIRTH
☐ New ☐ Change	APPLICANT				☐ Male ☐ Female	
☐ New ☐ Change	SPOUSE				☐ Male ☐ Female	
☐ New ☐ Change	CHILD				☐ Male ☐ Female	
☐ New ☐ Change	CHILD				☐ Male ☐ Female	
☐ New ☐ Change	CHILD				☐ Male ☐ Female	
☐ New ☐ Change	CHILD				☐ Male ☐ Female	

III Coverage Selection

COVERAGE DESIRED (Individual/Family Deductible):

☐ Short Term Plus 1000 ($1,000/$3,000)

☐ Short Term Plus 2500 ($2,500/$7,500)

☐ Short Term Plus 5000 ($5,000/$15,000)

☐ Short Term Plus 10000 ($10,000/$30,000)

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

LAST NAME: FIRST NAME: SOCIAL SECURITY NO.:

IV Health Questions

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 test, 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.

☐ YES	☐ NO	1. Will this policy replace present coverage? If "Yes", state termination date _____
☐ YES	☐ NO	2. Will there be any other health insurance in force on the policy effective date?
☐ YES	☐ NO	3. Is proposed insured, spouse or any dependent child (whether applying or not) now pregnant?
☐ YES	☐ NO	4. Within the last (5) years, have you or any proposed insured ever been diagnosed with, treated for, or received advice from a physician for: heart or circulatory system disorder (excluding high blood pressure); heart attack or chest pain; stroke; diabetes; cancer or tumor; infertility; schizophrenia, manic depression or bipolar disorder; alcoholism or alcohol abuse; drug abuse or chemical dependency?
☐ YES	☐ NO	5. In the past (5) years, have you or any proposed insured ever received medical services from a physician or other health care provider for HIV infection, AIDS, AIDS Related Complex or tested positive for HIV virus or other diseases related to the immune system other than HIV?

V Agreement

I understand that, if persons proposed for coverage are eligible and coverage is offered: (1) effective date of coverage will be 12:01 a.m. on the date I requested; (2) preexisting conditions[1] will not be covered; (3) coverage under this Contract will terminate on the last day of the twelfth month of coverage or at 11:59 p.m. on December 31st, whichever is sooner; (4) I may apply for another Short Term Security Contract subject to underwriting approval; and (5) deductible changes cannot be made after coverage is in effect. I understand that the Contract is conditioned upon the truth contained herein. I understand that any misstatement on this enrollment application may result in a denial of a claim, re-rate of the premium, discontinuation or rescission of coverage. I understand that if at any time it is determined 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 and/or it subsidiaries have the right to re-rate, terminate or rescind coverage for that person or for all persons under the application, and to recover any benefit payments for such ineligible person or persons. I understand my medical records will be maintained with strict confidentiality by Blue KC in accordance with applicable federal and state laws.

You agree that by checking "Yes" you consent and request that Blue Cross and Blue Shield of Kansas City, our affiliates, and those acting on our or their behalf, may call or text you using an automated telephone dialing system and/or a prerecorded message. The types of calls or texts you may receive include advertisements or telemarketing messages concerning our or our affiliates' benefits and services. You understand that consent is not a condition of purchase. ☐ YES ☐ NO

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.

THIS IS NOT QUALIFYING HEALTH COVERAGE ("MINIMUM ESSENTIAL COVERAGE") THAT SATISFIES THE HEALTH COVERAGE REQUIREMENT OF THE AFFORDABLE CARE ACT. IF YOU DON'T HAVE MINIMUM ESSENTIAL COVERAGE, YOU MAY OWE AN ADDITIONAL PAYMENT WITH YOUR TAXES.

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

If a broker or agent provided services associated with your selection and enrollment of a Blue KC Short Term Security contract, that broker or agent will receive a direct compensation of 15%.

Applicant's Signature:	Spouse's Signature:
Printed Name:	Spouse's Printed Name:
Date:	Date:
Signed at (City, State):	Signed at (City, State):

1. A Preexisting Condition is defined as any illness, injury or other condition for which medical advice, diagnosis, care or treatment was received or recommended during the 12 months prior to the Effective Date of coverage.

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

LAST NAME: FIRST NAME: SOCIAL SECURITY NO.:

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.

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.

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.

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		