Kansas City

An Independent Licensee of the Blue Cross and Blue Shield Association

Short-Term Security Application

BlueKC.com • P.O. Box 419169, Kansas City, MO 64141-6169 • 844-654-1474

REQUESTED EFFECTIVE DATE:_______________

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

Federal rule prohibits you from signing up for a Blue KC short term plan if you were the policy holder of a Blue KC short term plan in the last 12 months.

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 500 ($500/$1,500)
- ☐ Short Term 1000 ($1,000/$3,000)
- ☐ Short Term 2500 ($2,500/$7,500)
- ☐ Short Term 5000 ($5,000/$15,000)

Member Information (Please provide again to assist in case pages become separated)
LAST NAME: FIRST NAME: SOCIAL SECURITY NO.:

IV(a) Health Questions - ALL QUESTIONS MUST BE ANSWERED BEFORE APPLICATION IS 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.

☐ 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?

IV(b) Professional Services (Give COMPLETE details of any "Yes" answers to the questions in Section IV(a).)

QUESTION NO.	PERSON TREATED	CONDITION & TYPE OF TREATMENT	DATE OCCURRED	LAST DATE OF TREATMENT	CURRENT STATUS	COMPLETE NAME AND ADDRESS OF PROVIDER

IV(c) Prescription Medications – List ALL medications taken within the last 12 months by any family member listed

PERSON TREATED	NAME OF DRUG	DOSAGE	FREQUENCY	CONDITION OR ILLNESS	START DATE	STOP DATE	COMPLETE NAME AND ADDRESS OF PHYSICIAN

Member Information (Please provide again to assist in case pages become separated)
LAST NAME: FIRST NAME: SOCIAL SECURITY NO.:

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 third month of coverage unless renewed per the terms of your contract in which case coverage would terminate on the last day of the fourth month; and (4) 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 fraudulent statement or material 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 materially 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.

(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 3%.

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.:

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 816-395-3558 (local) or 888-989-8842.

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, APPEA

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/

PAYMENT METHOD

Please remember to enclose correct premium payment. Make checks payable to Blue Cross and Blue Shield of Kansas City.

- 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		