Kansas City

An Independent Licensee of the Blue Cross and Blue Shield Association

Individual BlueDental PPO/Choice Dental

BlueKC.com • P.O. Box 419169, Kansas City, MO 64141 • 844-654-1473

REQUESTED EFFECTIVE DATE: _____ Effective the 1st of each month ONLY Application must be received prior to the effective date	PLEASE CHECK EITHER "New Application" OR "Change": ☐ New Application For individuals who currently have dental coverage as a dependent with Blue Cross and Blue Shield of Kansas City (Blue KC), have you been continuously covered for at least 6 months? ☐ Yes ☐ No If "yes," please provide the certificate number (found on your Blue KC member I.D. card): _____ ☐ Change (If application is to be used as a change form, please specify below): ☐ Address Change ☐ Other Reason for Change (Required): _____	LIST BILL NO. _____

I Applicant /Family Information - List ONLY those individuals desiring coverage

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

II Billing Information

1. NAME				
2. *HOME ADDRESS	*CITY	*STATE	*COUNTY	*ZIP CODE
3. *BILLING ADDRESS (If different than above): ☐ Billing Only ☐ Billing and All Correspondence	*CITY	*STATE	*COUNTY	*ZIP CODE

4. DAYTIME PHONE NO.	5. HOME PHONE NO.	6. 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.

If you or your dependent currently have individual or group health coverage through Blue KC, please specify your certificate number (this information can be found on your Blue KC member I.D. card): _____ (Please provide all member I.D. numbers)

* 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.

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

LAST NAME: FIRST NAME: SOCIAL SECURITY NO.:

III

Dental PPO Base Plans: Check one if desired.	Standard Plan Details
☐ BlueDental Preventive 1000 Preventive (Type I)	Deductible: $0 PPO Network Coinsurance: 100% Choice Network Coinsurance: 85% Calendar Year Maximum: $1,000
☐ BlueDental 1000 Preventive (Type I) Basic (Type II)	Deductible: $50 for Type II PPO Network Coinsurance: 100% (I) / 80% (II) Choice Network Coinsurance: 85% (I) / 70% (II) Calendar Year Maximum: $1,000
☐ BlueDental Plus 1000 Preventive (Type I) Basic (Type II) Major (Type III)	Deductible: $50 (Type II) / $200 (Type III) PPO Network Coinsurance: 100% (I) / 80% (II) / 50% (III) Choice Network Coinsurance: 85% (I) / 70% (II) / 50% (III) Calendar Year Maximum: $1,000
☐ BlueDental Plus 1200 Preventive (Type I) Basic (Type II) Major (Type III)	Deductible: $50 (Type II) / $150 (Type III) PPO Network Coinsurance: 100% (I) / 80% (II) / 50% (III) Choice Network Coinsurance: 85% (I) / 70% (II) / 50% (III) Calendar Year Maximum: $1,200
☐ BlueDental Plus 1500 Preventive (Type I) Basic (Type II) Major (Type III)	Deductible: $50 (Type II) / $150 (Type III) PPO Network Coinsurance: 100% (I) / 80% (II) / 50% (III) Choice Network Coinsurance: 85% (I) / 70% (II) / 50% (III) Calendar Year Maximum: $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 6 months with no gap in coverage in order to waive any applicable waiting periods for Type 2 services. Coverage must be in force for the past 12 months with no gap in coverage in order to waive any applicable waiting periods for Type 3 services. Name(s) of individuals covered: _____ Carrier name(s): _____ Policy ID number(s): _____ Effective date(s): _____ Termination date(s): _____

IV Payment Option

The membership premium is to be

☐ Automatically deducted (electronic funds transfer) from my checking account monthly ☐ Charged to my credit card

☐ Billed to my home every month

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

V Agreement

I request coverage under the Preferred-Care Dental 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. I understand that any misstatement on this enrollment application may result in a denial of a claim and/or discontinuation 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 policy's definition of dependent, or I misrepresented any of the information contained herein, Blue KC has the right to cancel or rescind coverage for the person or for all persons under the application, and to recover any benefit payments for such ineligible person(s). I understand no statement I make voids my coverage or reduces my benefits after my coverage has been in force for two (2) years from the effective date, unless my statements are material to the risk assumed and contained in my written application. I understand my dental records will be maintained with strict confidentiality by Blue KC in accordance with applicable federal and state laws. I understand that the Contract and other documents, notices and communications regarding my coverage may be transmitted electronically. 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

Applicant's (Parent/Guardian's) Signature:	Spouse's Signature (if enrolling):
Printed Name:	Printed Name:
Date:	Date:

VI 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

[VII] Notices

Discrimination is Against the Law:
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. Blue KC does not exclude people or treat them differently because 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, 816-395-6340 (local), 844-395-7126 (Toll free), languagehelp@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, orsex, youcanfileagrievancewiththe Appeals Department, POBox 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, 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
1-800-868-1019, 800-537-7697 (TDD)

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

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

LAST NAME: FIRST NAME: SOCIAL SECURITY NO.:

Need this Communication in Another Language?

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.

1. 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.

2. 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。

3. 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.

4. 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.

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

6. Laotian: ຖ້າທ່ານ, ຫ ົ ືຄົນທ ່ທ່ານກ ໍາລ ັງຊ ່ວຍເຫ ົ ືອ, ມ ຄ ໍາຖ າມກ ່ ຽວກ ັບ Blue KC, ທ ່ານມ ສ ິດທ ່ ໄ ດ ້ ຮ ັ ບການຊ ່ ວຍເຫ ົ ືອແລະ ຂ ໍ ້ ມ ູ ນຂ ່ າວສ ານທ ່ ເ ປ ັ ນພ າສ າຂ ອງທ ່ ານ ບ ໍ ່ ມ ຄ ່ າ ໃ 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.

7. Arabic: إن لك لديك أ ولي خص تساعده أ شخص Blue KC، فلديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون اية تكلفة. للتحدث مع مترجم اتصل ب 1-844-395-7126.

8. 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 sa 1-844-395-7126.

9. 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.

10. 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 телефону 1-844-395-7126.

11. Persian: اگر شما يا شخصی که به او کمک میکنید، سوال در مورد Blue KC داشته باشید حق اين را داريد که کمک و اطلاعات به زبان خود را بهطور رايگان دريافت نمايد. 1-844-395-7126 تماس حاصل نمايد .

12. Serbo-Croation: Ukoliko Vi ili neko kome Vi pomažete ima pitanje o Blue KC, imate pravo da besplatno dobijete pomoć i informacije na Vašem jeziku. Da biste razgovarali sa prevodiocem, nazovite 1-844-395-7126.

13. Pennsylvanian Dutch: "Wann du hoscht en Froog, odder ebber, wu du helfscht, hot en Froog baut Blue KC, hoscht du es Recht fer Hilf un Information in deinre eegne Schprooch griege, un die Hilf koschtet nix. Wann du mit me Interpreter schwetze witt, kannscht du 1-844-395-7126 uffrufe.

14. 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.

15. 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.

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		