**EMPLOYER USE ONLY:** BLUE KC GROUP NO. _____ CLASS NO. _____ SUBGROUP NO. _____

Kansas City

An Independent Licensee of the Blue Cross and Blue Shield Association

# Group Application

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

## GROUPS WITH 2 TO 50 EMPLOYEES

Please Complete All Boxes LEGIBLY (Print) IN BLUE OR BLACK INK and Sign.

Preferred-Care Blue PPO ⋮ BlueSelect Plus PPO

## I Group Information

| | | | |
|---|---|---|---|
| 1. COMPANY NAME (FULL LEGAL NAME) | | | 2. REQUESTED EFFECTIVE DATE |
| 3. STREET ADDRESS | | | 4. P.O. BOX |
| 5. CITY | 6. STATE | 7. ZIP | 8. COUNTY |
| 9. CONTACT NAME | 10. TITLE | | 11. FEDERAL TAX ID NUMBER |
| 12. PHONE NUMBER | 13. FAX NUMBER | 14. E-MAIL ADDRESS | |
| 15. NAME OF PREVIOUS HEALTH INSURANCE CARRIER | | | |
| 16. DATE BUSINESS ESTABLISHED | 17. NATURE OF BUSINESS, INCLUDING SUBSIDIARIES | | 18. SIC CODE (IF KNOWN) |

## II Coverage Selection: Medical

**19.** APPLICATION FOR Medical Coverage *Select up to 3 products under Preferred-Care Blue or BlueSelect only. Applies to Missouri employers only:* If Spira products are offered, a non-Spira product must also be offered. Spira benefits are limited to services provided by Preferred Providers, except for Emergency Services and certain Mental Health office visits. Services provided by Non-Preferred Providers are not covered, except as specifically provided. Covered Services for certain Mental Health office visits include 2 office visits per Calendar Year for the diagnosis or assessment of Mental Illness to a Non-Preferred Provider acting within the scope of their license.:

**PREFERRED-CARE BLUE**

| First (PPO) | Classic (PPO) | Saver* (PPO) | Traditional (PPO) | Value (PPO) |
|---|---|---|---|---|
| ☐ Gold 1,850 | ☐ Gold 1,250 | ☐ Gold 1,500 | ☐ Silver 3,500 | ☐ Bronze 7,750 |
| ☐ Silver 5,000 | ☐ Silver 5,000 | ☐ Silver 3,500 | | |
| ☐ Bronze 6,850 | | ☐ Bronze 6,000 | | |

**BLUESELECT PLUS**

| Traditional (PPO) | Saver* (PPO) | Spira Care (EPO) | Value (PPO) |
|---|---|---|---|
| ☐ Silver 3,500 | ☐ Silver 3,500 | ☐ Gold 2,750 | ☐ Bronze 7,750 |
| ☐ Bronze 6,950 | ☐ Bronze 6,000 | ☐ Silver 5,000 | |
| | | ☐ Bronze 8, 000 | |
| | | ☐ Silver HSA 3,750 | |
| | | ☐ Bronze HSA 5,750 | |

## III Coverage Selection: Vision

20. APPLICATION FOR Vision Coverage *Groups with 10 or more employees enrolled in a vision product may choose two (2) vision plans.*

| | | | |
|---|---|---|---|
| ☐ Blue Vue Base | ☐ Blue Vue 0/130 | ☐ Blue Vue 0/150 | ☐ Blue Vue 0/200 |
| ☐ Blue Vue 10/100 | ☐ Blue Vue 10/130 | ☐ Blue Vue 10/150 | ☐ Blue Vue 10/200 |

**EMPLOYER USE ONLY:** BLUE KC GROUP NO. _____ CLASS NO. _____ SUBGROUP NO. _____

## IV Coverage Selection: Dental

**21.** Application for Dental Coverage *Choose to offer your employees Dental coverage by selecting one base plan. Standard plan details may not be a complete description of all plan features. Type IV services are available only for eligible groups with ten (10) or more employees enrolled in a dental product. Blue KC does not provide Exchange-certified standalone pediatric dental benefits compliant with the Federal Patient Protection and Affordable Care Act (PPACA) and does not satisfy the "reasonable assurance" requirement.*

Group Dental ☐ Yes ☐ No

| No. | **Blue Dental (Type I / Type II)** | **$50 Individual Deductible / $150 Family Deductible** |
|---|---|---|
| 1 | ☐ 100% Type I / 80% Type II | $1,000 Calendar Year Maximum |
| | **Blue Dental Plus (Type I / Type II / Type III)** | **$50 Individual Deductible / $150 Family Deductible** |
| 2 | ☐ 100% Type I / 80% Type II / 50% Type III | $1,000 Calendar Year Maximum |
| 3 | ☐ 100% Type I / 80% Type II / 50% Type III | $1,500 Calendar Year Maximum |
| 4 | ☐ 100% Type I / 90% Type II / 60% Type III | $1,000 Calendar Year Maximum |
| 5 | ☐ 100% Type I / 90% Type II / 60% Type III | $1,500 Calendar Year Maximum |
| | **Blue Dental Preferred (Type I / Type II / Type III / Type IV)** | **$50 Individual Deductible / $150 Family Deductible With Orthodontics $1,000 Lifetime Maximum** |
| 6 | ☐ 100% Type I / 80% Type II / 50% Type III / 50% Type IV | $1,000 Calendar Year Maximum |
| 7 | ☐ 100% Type I / 80% Type II / 50% Type III / 50% Type IV | $1,500 Calendar Year Maximum |
| 8 | ☐ 100% Type I / 90% Type II / 60% Type III / 50% Type IV | $1,000 Calendar Year Maximum |
| 9 | ☐ 100% Type I / 90% Type II / 60% Type III / 50% Type IV | $1,500 Calendar Year Maximum |

**EMPLOYER USE ONLY:** BLUE KC GROUP NO. _____ CLASS NO. _____ SUBGROUP NO. _____

## V Eligibility/Participation/Contribution

**22.** Are you aware of any disabled dependents? ☐ YES (Give details on a separate page) ☐ NO

**23.** Are any individuals not actively at work (excluding scheduled vacation)? ☐ YES (Give details on a separate page) ■ NO

**24.** Are there any owners/partners to be excluded from Worker's Compensation? ☐ YES ☐ NO If yes, please provide names.

**25.** Effective date for new employees and their dependent(s) is:
☐ Date of hire ☐ First of the month following date of hire
☐ First of the month following 30 days ☐ First of the month following 60 days

**26.** Total number of full-time employees: _____ Total number of part-time employees: _____
Full-time is defined as working at least 30 hours per week.

**27.** Total number of eligible full-time employees applying: _____

**28.** Are there any eligible employees in their new hire waiting period? ☐ YES ☐ NO If yes, please provide names and submit applications.

**29.** Will any present or former employees/dependents be electing COBRA/State Continuation on this new BlueKC group policy? ☐ YES ☐ NO
If yes, please provide names.

**30.** ARE ANY EMPLOYEES OF ANY SUBSIDIARY OR AFFILIATED COMPANIES TO BE COVERED UNDER THIS PLAN?
☐ YES ☐ NO (If yes, complete all information) Company Name(s) _____
_____ Federal Tax ID Number of Each Subsidiary _____
No. of Employees _____ Address _____ City _____
State _____ Zip _____ County _____

**31.** Will coverage be offered to employees of one or more non-affiliated companies? ☐ YES ☐ NO

## VI USAble Life Insurance Information

**32.** APPLICATION FOR Life Insurance Coverage *Select one Package only. Dependent life coverage for spouses ($5,000) and children ($2,000) ages 6 months up to 26 years included in all packages. Package summary may not be a complete description of all plan features. For custom life quotes on groups with 10 or more employees, a separate application must be requested. Please contact a USAble representative at 800-370-5856. Employee participation must be 100% if Employer contributes 100% of the cost of the premium.*

If you have 2 or more employees enrolled in Life insurance, you may select Packages 5 through 8. If you contribute less than 100% of the premium, 100% participation is required if 3 or fewer Employees are enrolled; if 4 or more Employees are enrolled, at least 75% participation is required.

| ☐ **Package 5** | ☐ **Package 6** | ☐ **Package 7** | ☐ **Package 8** |
|---|---|---|---|
| $25,000 Life Employee | $25,000 Life Employee | $35,000 Life Employee | $35,000 Life Employee |
| No Long-Term Disability Coverage. | Includes Package 6 Long-Term Disability Coverage. | No Long-Term Disability Coverage. | Includes Package 8 Long-Term Disability Coverage. |

If you have 5 or more employees enrolled in Life insurance, you may select from Packages 5 through 8 above, or from Packages 9 and 10 below. Employer contribution must be at least 75% if Package 9 or 10 is selected.

| ☐ **Package 9** | ☐ **Package 10** |
|---|---|
| $50,000 Life Employee | $50,000 Life Employee |
| No Long-Term Disability Coverage. | Includes Package 10 Long-Term Disability Coverage. |

**33.** Employer Contribution for Life/Accident & Disability Coverage (either in percentage or dollar amounts): _____
Employer contribution must be a minimum of 25% for employee coverage.

**34.** Will the following coverages be replacing similar coverage from a prior carrier? If yes, please provide a copy of the prior plan.

| | Coverage | If Yes, Prior Carrier Information | Termination Date |
|---|---|---|---|
| ☐ YES ☐ NO | Life/Accident & Disability | | |

**EMPLOYER USE ONLY:** BLUE KC GROUP NO. _____ CLASS NO._____ SUBGROUP NO. _____

## USAble Life Coverage (continued)

**35.** APPLICATION FOR Long-Term Disability Coverage *Select one Package only. Package summary may not be a complete description of all plan features. Employee participation must be 100% if Employer contributes 100% of the cost of the premium.*

If you have 2 or more employees enrolled in Life insurance, you may select Packages 5 through 8. If you contribute less than 100% of the premium, 100% participation is required if 3 or fewer Employees are enrolled; if 4 or more Employees are enrolled, at least 75% participation is required.

| ☐ Package 5 | ☐ **Package 6** | ☐ Package 7 | ☐ **Package 8** |
|---|---|---|---|
| No Employee Long-Term Disability. | $500 Employee Long-Term Disability. | No Employee Long-Term Disability. | $1,000 Employee Long-Term Disability. |
| Includes Package 5 Life Coverage. | Includes Package 6 Life Coverage. | Includes Package 7 Life Coverage. | Includes Package 8 Life Coverage. |

If you have 5 or more employees enrolled in Life insurance, you may select from Packages 5 through 8 above, or from Packages 9 and 10 below. Employer contribution must be at least 25% if Package 9 or 10 is selected.

| ☐ Package 9 | ☐ **Package 10** |
|---|---|
| No Employee Long-Term Disability. | $1,500 Employee Long-Term Disability. |
| Includes Package 9 Life Coverage. | Includes Package 10 Life Coverage. |

**36.** W-2 Service Options for Long-Term Disability

☐ Option 1: Withhold Federal Income Taxes and the Employee's portion of FICA. Prepare and File W-2 Forms.

☐ Option 2: Withhold Federal income Taxes and the employee's portion of FICA. Policyholder waives W-2 Forms Services.

A detailed description of the W-2 services elected by the Policyholder pursuant to this application will be sent to the Policyholder by mail. Such services will be performed in accordance with the above election and established standard procedures.

**37.** Employer Contribution for Life/Accident & Disability Coverage (either in percentage or dollar amounts): _____
Employer contribution must be a minimum of 25% for employee coverage.

**38.** Will the following coverages be replacing similar coverage from a prior carrier? If yes, please provide a copy of the prior plan.

| | Coverage | If Yes, Prior Carrier Information | Termination Date |
|---|---|---|---|
| ☐ YES ☐ NO | Long-Term Disability | | |

## VII USAble Life Information

It is agreed that the group insurance, subject to the terms and conditions of the policies applied for, will take effect as of the effective date requested, provided that this application is approved by USAble Life in writing, insurance shall not become effective unless a minimum of eligible individuals have enrolled. Changes in benefit amounts will become effective on the policy anniversary date coincident with or next following the date of change. If this application for insurance is not approved, insurance shall not become effective and any advance payment, whether required or voluntary, will be refunded. Approval of this application is not guaranteed. The employer should not cancel any other coverage until notified by USAble Life in writing that this application is approved. NO AGENT OR BROKER IS AUTHORIZED TO BIND COVERAGE, APPROVE APPLICATIONS, MODIFY POLICIES OR ALTER OR WAIVE ANY RIGHTS OR REQUIREMENTS OF USAble Life. USAble Life is not affiliated with Blue Cross and Blue Shield of Kansas City, does not offer Blue Cross or Blue Shield products or services, and is solely responsible for the life insurance coverage.

**EMPLOYER USE ONLY:** BLUE KC GROUP NO. _____ CLASS NO. _____ SUBGROUP NO. _____

## VIII IMPORTANT - Please Read Carefully

The Company represents that the information provided above is complete and accurate and can be substantiated by business records maintained by the Company. The Company understands that the information provided herein shall be the basis of any coverage issued and that this application will be attached to and incorporated into any policy that may be issued hereunder by Blue Cross and Blue Shield of Kansas City ("Blue KC"). The Company agrees to provide the documentation requested by insurer, which establishes that, all applicable eligibility and participation requirements of the Group Contract are met. The Company agrees that providing incomplete, inaccurate, or untimely information may affect the individual's or group's coverage or may affect the rates. The Company shall notify insurer promptly of any changes in this information that may affect the eligibility of employees or their dependents, including the addition of any newly eligible employees or dependents. Insurer shall be entitled to rely on the most current information in its possession regarding eligibility of employees and their dependents in providing coverage.

During and after termination of the Group Contract, the Company grants insurer permission to use and/or transfer to third parties for research and analysis purposes the claims and related medical data in insurer's possession. The parties shall maintain the confidentiality of any information relating to Covered Persons in accordance with any applicable laws. Neither party shall disclose any confidential business information of the other party without the prior written consent of that party.

It is understood and agreed that insurance will be effective only on the date specified by insurer after the application has been approved by the insurer and after the first full premium has been paid. The Company's canceled check is a receipt for the deposit. The deposit will be applied to the first premium due if the application for group coverage is approved. The deposit is not refundable after the group coverage has been approved and issued.

DO NOT CANCEL EXISTING MEDICAL COVERAGE UNTIL YOU RECEIVE WRITTEN NOTIFICATION OF APPROVAL.

Employer Signature _____ Date _____

Title _____

| Agent Information | | Blue KC Office Use Only | |
|---|---|---|---|
| AGENT NAME (PLEASE PRINT) | AGENT NUMBER | COMMISSION ARRANGEMENT HEALTH | COMMISSION ARRANGEMENT DENTAL |
| PHONE NUMBER | | COMMISSION ARRANGEMENT LIFE | COMMISSION ARRANGEMENT VISION |
| AGENCY NAME | | BLUE KC GROUP NUMBER | BLUE KC PARENT NUMBER |
| AGENT OFFICE CONTACT E-MAIL | | SALES REP NUMBER | |

AGENT SIGNATURE _____ DATE _____

## Notices

### 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

Your coverage does not include elective pregnancy termination coverage.