



Kansas City

An Independent Licensee of the Blue Cross and Blue Shield Association

Employee Application and Change Form



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

GROUPS WITH 51-99 EMPLOYEES

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

Preferred-Care Blue PPO ; Blue-Care HMO*

If application is to be used as a Change Form, please specify event below.

DATE OF EVENT: _____ PROPOSED EFFECTIVE DATE: _____

- Birth
 Change of Address
 Divorce
 Marriage
 Death
 Change of Beneficiary
 Adoption/Placement
 Loss of Other Group Coverage
 Reaching Lifetime Benefit Maximum

I Employee Information Only

1. LAST NAME		FIRST NAME		MIDDLE INITIAL		2. STREET ADDRESS	
3. CITY			STATE			ZIP CODE	
5. E-MAIL ADDRESS <i>Blue KC may use this e-mail address to provide documents, materials, and other notices related to this coverage.</i>						6. BIRTH DATE	7. SOCIAL SECURITY NO.
8. HIRE DATE		9. EMPLOYER			POSITION		10. NO. OF HOURS WORKED PER WEEK
4. HOME PHONE NO.							
WORK PHONE NO.							

II Medical Coverage Selection

11. I Elect The Following Coverage (Select only one available Product. Product availability is limited to your Employer's selections.):

AffordaBlue (PPO)

- \$2,500 \$5,000

Preferred-Care Blue (PPO)

- \$300 \$500 \$1,000 \$1,500 \$2,000 \$3,500

High Deductible Health Plan (HDHP)

- \$2,000 \$2,500 \$5,000

PersonalBlue Health Reimbursement Arrangement (HRA)

- \$2,000 \$2,500 \$5,000

BlueSaver (For use with an HSA)

- \$2,000 \$2,500 \$5,000

HMO

An HSA will be established unless you indicate otherwise. Please complete section VIII.

- No, I do not want to open an HSA

Medical Coverage To Be For (Select only one.):

- Self
 Self + Child(ren)
 Self + Spouse
 Self + Family
 Self + Domestic Partner

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

CHECK APPROPRIATE BOX	SOCIAL SECURITY NO.	LAST NAME	FIRST NAME	M.I.	DATE OF BIRTH	GENDER	INDICATE COVERAGE	PRIMARY CARE PHYSICIAN (Complete only if applying for HMO Coverage)	CURRENT PATIENT
<input type="checkbox"/> New	EMPLOYEE					<input type="checkbox"/> Male	<input type="checkbox"/> Medical	PCP Name:	<input type="checkbox"/> Yes
<input type="checkbox"/> Change						<input type="checkbox"/> Female	<input type="checkbox"/> Dental	PCP No.:	<input type="checkbox"/> No
<input type="checkbox"/> New	SPOUSE					<input type="checkbox"/> Male	<input type="checkbox"/> Medical	PCP Name:	<input type="checkbox"/> Yes
<input type="checkbox"/> Change						<input type="checkbox"/> Female	<input type="checkbox"/> Dental	PCP No.:	<input type="checkbox"/> No
<input type="checkbox"/> New	CHILD					<input type="checkbox"/> Male	<input type="checkbox"/> Medical	PCP Name:	<input type="checkbox"/> Yes
<input type="checkbox"/> Change						<input type="checkbox"/> Female	<input type="checkbox"/> Dental	PCP No.:	<input type="checkbox"/> No
<input type="checkbox"/> New	CHILD					<input type="checkbox"/> Male	<input type="checkbox"/> Medical	PCP Name:	<input type="checkbox"/> Yes
<input type="checkbox"/> Change						<input type="checkbox"/> Female	<input type="checkbox"/> Dental	PCP No.:	<input type="checkbox"/> No
<input type="checkbox"/> New	CHILD					<input type="checkbox"/> Male	<input type="checkbox"/> Medical	PCP Name:	<input type="checkbox"/> Yes
<input type="checkbox"/> Change						<input type="checkbox"/> Female	<input type="checkbox"/> Dental	PCP No.:	<input type="checkbox"/> No

IV Ancillary Coverage Selection

<p>Dental (Select only one. Product availability is limited to your Employer's selections.):</p> <p><input type="checkbox"/> Self <input type="checkbox"/> Self + Spouse</p> <p><input type="checkbox"/> Self + Family <input type="checkbox"/> Self + Child(ren)</p> <p><input type="checkbox"/> Self + Domestic Partner</p>	<p>Life (If offered by your Employer, Life coverage is available only for Employees who work an average of 25 hours a week or more.):</p> <p><input type="checkbox"/> Life/AD&D (See Section IX) <input type="checkbox"/> Long Term Disability (LTD)</p> <p><input type="checkbox"/> Dependent Life (Dep Life) <input type="checkbox"/> Supplemental Life</p> <p><input type="checkbox"/> Short Term Disability (STD) <input type="checkbox"/> Waive (I choose to waive all Life products listed.)</p>
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V Waiver of Coverage Selection

<p>I Decline Coverage For</p> <p>Medical <input type="checkbox"/> Self <input type="checkbox"/> My Spouse <input type="checkbox"/> My Dependent Child(ren)</p> <p>Dental <input type="checkbox"/> Self <input type="checkbox"/> My Spouse <input type="checkbox"/> My Dependent Child(ren)</p>	<p>Due to:</p> <p><input type="checkbox"/> Existence of Other Group Health Coverage</p> <p><input type="checkbox"/> Medicare or Medicaid</p> <p><input type="checkbox"/> Existence of Other Individual Health Coverage</p> <p><input type="checkbox"/> Other Reason (explain) _____</p>
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If you are declining medical coverage for yourself or your dependents (including your spouse) because of other group coverage, you or your dependents may in the future be able to enroll in this plan, provided that you request enrollment within 31 days after your other group coverage ends. In addition, you may be able to enroll yourself and your dependent(s), provided that you request enrollment within 31 days after a marriage, birth, adoption or placement for adoption. If you decline coverage for yourself or your dependents while Medicaid coverage or coverage under a state children's health insurance program (CHIP) is in effect, you and your dependents may be able to enroll in this plan if you or your dependents lose eligibility for that coverage, provided you request enrollment within 60 days after that coverage ends. If you are declining medical and/or dental coverage for any other reason, or if you fail to complete this form, you may be limited to enrolling only during the annual enrollment period. If you or your dependents become eligible for a state premium assistance subsidy from Medicaid or CHIP with respect to this plan, you and your dependents may be eligible to enroll in this plan, provided you request enrollment within 60 after such eligibility is determined. If you decline the life, dependent life, short term disability, long term disability or supplemental life coverage and elect to enroll for coverage at a later date, you may be required to submit, at your own expense, evidence of insurability to USABLE Life. To request a special enrollment for medical and/or dental coverage, please contact our Member Services Department at (816) 395-2950.

VI Other Health Insurance Carrier (for Coordination of Benefits)

1. On the day the coverage begins, will any family members be covered by other health or dental insurance or Medicare, including continuation of coverage?

YES NO If yes, answer all questions below. Attach sheet if more than one additional policy will be in force.

COVERAGE TYPE <input type="checkbox"/> Medical Insurance <input type="checkbox"/> Dental Insurance	INSURANCE COMPANY NAME (AREA CODE) PHONE NO.	POLICY NO.
NAME OF INSURED	INSURED'S EMPLOYER NAME	EFFECTIVE DATE
TERMINATION DATE		

FAMILY MEMBERS COVERED

1. _____ 2. _____ 3. _____

2. Are any of your dependent children subject to a divorce decree or court order? YES NO
 If yes, whose coverage is primary? Yours The Other Parent's

3. If you or your dependent(s) have Medicare, include a copy of your Medicare card(s) with this Application.
 Do you or your dependent(s) have Medicare? YES NO If yes, are you actively working? YES NO
 Are you retired? YES NO If yes, please provide date of retirement: _____

4. Are you or any of your dependent(s) covered under COBRA or State Continuation? YES NO
 If yes, please provide the effective date and future termination date of coverage:
 Effective Date: _____ Future Termination Date: _____

VII(a) All Questions Must be Answered Before Your Application Will be 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.

Please check (✓) appropriate box if you or a dependent applying for coverage ever received in the past five (5) years, medical services from a health care provider for any of the conditions listed below. If checked yes, please explain completely in the additional medical information section below. **WITHIN THE LAST 5 YEARS HAVE YOU OR ANY DEPENDENTS APPLYING FOR COVERAGE BEEN DIAGNOSED OR TREATED FOR ANY OF THE FOLLOWING CONDITIONS?:**

- | | | |
|---|---|---|
| <p>YES NO</p> <p>1. <input type="checkbox"/> <input type="checkbox"/> Bone/Joint/Muscular Disorder/
Joint Replacement</p> <p>2. <input type="checkbox"/> <input type="checkbox"/> Arthritis/Gout/Back or Neck
Disorder</p> <p>3. <input type="checkbox"/> <input type="checkbox"/> Fibromyalgia/Chronic Fatigue
Syndrome</p> <p>4. <input type="checkbox"/> <input type="checkbox"/> Lupus - Type _____</p> <p>5. <input type="checkbox"/> <input type="checkbox"/> Nervous System/Brain Disorder/
Alzheimer's</p> <p>6. <input type="checkbox"/> <input type="checkbox"/> Epilepsy/Seizure Disorder</p> <p>7. <input type="checkbox"/> <input type="checkbox"/> Multiple Sclerosis</p> <p>8. <input type="checkbox"/> <input type="checkbox"/> Parkinson's Disease</p> <p>9. <input type="checkbox"/> <input type="checkbox"/> Heart/Circulatory Disorder</p> <p>10. <input type="checkbox"/> <input type="checkbox"/> Stroke</p> <p>11. <input type="checkbox"/> <input type="checkbox"/> High Blood Pressure
(Last reading _____
Date _____)</p> <p>12. <input type="checkbox"/> <input type="checkbox"/> Blood Disorder/Leukemia/
Hemophilia</p> | <p>YES NO</p> <p>13. <input type="checkbox"/> <input type="checkbox"/> Elevated Cholesterol
(Last reading _____
Date _____)</p> <p>14. <input type="checkbox"/> <input type="checkbox"/> Diabetes-Hemoglobin A1C
(Last reading _____
Date _____)</p> <p>15. <input type="checkbox"/> <input type="checkbox"/> HIV/AIDS/AIDS Related Complex</p> <p>16. <input type="checkbox"/> <input type="checkbox"/> Abnormal Pap Smear
(If yes, submit copies of last 2 pap
smear results)</p> <p>17. <input type="checkbox"/> <input type="checkbox"/> Infertility/Reproductive Disorder</p> <p>18. <input type="checkbox"/> <input type="checkbox"/> Cancer - Type _____</p> <p>19. <input type="checkbox"/> <input type="checkbox"/> Tumor/Cyst/Polyp</p> <p>20. <input type="checkbox"/> <input type="checkbox"/> Respiratory/Lung Disorder/Asthma/
Tuberculosis</p> <p>21. <input type="checkbox"/> <input type="checkbox"/> Emphysema/Chronic Obstructive
Pulmonary Disease</p> <p>22. <input type="checkbox"/> <input type="checkbox"/> Pancreatic Disorder</p> <p>23. <input type="checkbox"/> <input type="checkbox"/> Thyroid Disorder/Goiter</p> | <p>YES NO</p> <p>24. <input type="checkbox"/> <input type="checkbox"/> Kidney/Bladder/Urinary Disorder</p> <p>25. <input type="checkbox"/> <input type="checkbox"/> Liver Disorder/Hepatitis A B C</p> <p>26. <input type="checkbox"/> <input type="checkbox"/> Chiropractic Treatment – Number of
Visits in Last 12 Months _____</p> <p>27. <input type="checkbox"/> <input type="checkbox"/> Digestive/Intestinal Disorder</p> <p>28. <input type="checkbox"/> <input type="checkbox"/> Crohn's Disease/Diverticulitis/
Diverticulosis</p> <p>29. <input type="checkbox"/> <input type="checkbox"/> Mental/Nervous Disorders</p> <p>30. <input type="checkbox"/> <input type="checkbox"/> Schizophrenia/Manic-Depression/
Suicide Attempt</p> <p>31. <input type="checkbox"/> <input type="checkbox"/> Attention Deficit Disorder</p> <p>32. <input type="checkbox"/> <input type="checkbox"/> Anorexia/Bulemia</p> <p>33. <input type="checkbox"/> <input type="checkbox"/> Any Other Abnormality/Deformity/
Birth Defect (List all below)</p> <p>34. <input type="checkbox"/> <input type="checkbox"/> Glaucoma-Eye Pressure Readings
R _____ L _____</p> <p>35. <input type="checkbox"/> <input type="checkbox"/> Eye Disorders/Cataracts</p> |
|---|---|---|

36. PLEASE LIST ANY OTHER CONDITION(S), DIAGNOSED OR TREATED IN THE LAST 5 YEARS, NOT MENTIONED ABOVE: _____

LAST NAME _____

FIRST NAME _____

VII(b) Additional Medical Information - List below full details to questions answered in Section VIII(a) (attach sheet if necessary)

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

VII(c) Employee and Family Information - Employee and Employee's Dependents to be Enrolled (attach sheet if necessary)

Please check appropriate box to answer the following questions. If the Yes box is checked, please explain completely and in detail.

A. Are you or any family member or dependent currently pregnant? (Including any dependent not applying for coverage?) YES NO
 If yes, Name(s) _____ Due Date(s): _____
 Any multiple births anticipated? YES NO

B. Within the past 12 months have you or any dependents been a patient in the hospital? YES NO
 If yes, who _____ Number of hospital admissions _____
 Length of stays _____ Reason for hospitalizations _____

C. Within the past 12 months have you or any dependents been advised to have surgery, treatments, tests or studies NOT YET PERFORMED?
 YES NO
 If yes, Name(s) _____ Type of test, surgery, treatment or study _____
 Date performed or scheduled _____

D. Within the past 12 months have you or any dependents received Emergency Room Care? YES NO
 If yes, Name(s) _____ Number of ER visits in past 12 months _____
 Reason(s) for visit(s) _____

E. Have you or any of your dependents, consulted a physician, psychiatrist, psychologist, social worker, chiropractor, nurse practitioner, physical, occupational or speech therapist or any other health care professional for any reason, including an annual physical in the last 5 years? YES NO
 If yes, please explain _____

F. Has any family member had individual or group counseling the last 12 months? YES NO
 If yes, Name(s) _____ Frequency of counseling _____
 Date of last counseling session _____

G. Have you or any of your dependents, ever had or been advised to have an organ transplant of any type in the last 5 years? YES NO
 If yes, Name(s) _____ Type _____

H. Have you or any of your dependents, ever used or been treated, or counseled due to use of the following in the last 5 years:
 a) Use of alcohol, sedatives, hallucinogens, illegal substances, narcotics or any other drugs, other than those prescribed by a physician.
 YES NO
 b) If yes to any items in (a) please indicate types of use; treatment; and, dates. Date since last use? _____
 Date and Type of Treatment: _____
 c) Been convicted of a DUI in the last 5 years? YES NO If yes, Date(s) _____

I. Please list all prescription medications taken within the last 12 months by you or any of your dependents.

J. Have you or any of your dependents, ever smoked or used tobacco products, including cigarettes, cigars, pipes, or chewing tobacco in the last 5 years? YES NO
 If yes, Name(s) _____ For how long? _____
 How much used daily? _____ If no longer using tobacco products, when did you/dependent(s) quit? _____

K. Are any dependents disabled? YES (Give details on a separate page) NO

LAST NAME _____

FIRST NAME _____

Prescription Information (attach sheet if necessary)

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

L. In the past 2 years, has any person listed on this application discontinued medication without approval of a physician or failed to take medication prescribed by a physician?

YES NO *Name of medication* _____

Reason prescribed _____

Name of person _____

Medical Questionnaire Continued (attach sheet if necessary)

ANY ADDITIONAL INFORMATION

LAST NAME _____

FIRST NAME _____

VIII

If You Are Enrolling in a BlueSaver PPO Plan and Plan to Establish an HSA With Your Employer's Preferred Banking Institution, Please Complete the Following:

EMPLOYEE'S SOCIAL SECURITY NUMBER *(UNDER FEDERAL RULES, YOUR SOCIAL SECURITY NUMBER IS REQUIRED TO ESTABLISH AN HSA)*

PHYSICAL ADDRESS *(IF YOU PROVIDED A POST OFFICE BOX IN SECTION I, A PHYSICAL ADDRESS IS REQUIRED UNDER FEDERAL RULES TO ESTABLISH AN HSA)*

IX

If You Are Enrolling in Life Insurance, Please Complete the Following: (attach sheet if necessary)

Employee's Earnings Hourly _____ Monthly _____ Yearly _____

PRIMARY BENEFICIARY(IES) (Will receive proceeds if living at death of Employee):

NAME (LAST, FIRST, M.I.)	ADDRESS	SOCIAL SECURITY NO.	BIRTHDATE	RELATIONSHIP	PERCENTAGE

Total must equal 100% =

CONTINGENT BENEFICIARY(IES) (Will receive proceeds if Primary Beneficiary(ies) are not living):

NAME (LAST, FIRST, M.I.)	ADDRESS	SOCIAL SECURITY NO.	BIRTHDATE	RELATIONSHIP	PERCENTAGE

(For new coverage with USABLE Life, or when changing a beneficiary under existing coverage, this designation revokes any existing beneficiary designation you have made.)

Total must equal 100% =

X Agreement and Acknowledgement

I request coverage under the Group Contract(s) ("Contract") issued by Blue Cross and Blue Shield of Kansas City ("Blue KC") and Good Health HMO, Inc. d/b/a Blue Care and coverage under the Group Life Policy ("Policy") issued by USABLE Life as may from time to time be amended. I authorize my Employer to deduct from my earnings any required contributions. I understand coverage under the Contract and coverage under the Group Life Policy issued by USABLE Life will be available subject to the exclusions, limitations and benefits described in, as applicable, the Contract and the Group Life Policy issued by USABLE Life and the USABLE Life certificate. I authorize any physician, medical practitioner, hospital, clinic, or other medically related facility, insurance or reinsurance company, having information on me or any member of my family (only those who have applied for coverage on this application) regarding our mental and physical health, other insurance coverage, hazardous activities, character, general reputation, finances, and vocation to give to USABLE Life, its reinsurers, or its legal representative any and all such information to use for underwriting insurance. I authorize all said sources, to give such records or knowledge to any agency employed by the company to collect and transmit such information in order to facilitate its rapid submission. I agree that this authorization shall be valid for two (2) years from the application date. I agree that a photocopy of this authorization shall be as valid as the original, and I understand that a copy is available to me or my representative upon request. I represent that the statements and answers in this application are true, complete and correctly recorded. I understand that the statements and answers provided by me in this application shall be a basis of any coverage issued and the coverage is conditioned upon its truth.

I understand that if at any time it is determined by Blue KC or USABLE Life that a person listed on this application did not meet the Contract's or Policy's definition of dependent, Blue KC and/or USABLE Life has the right to terminate or rescind coverage for that person or for all ineligible persons under the application, and to recover any benefit payments made for such ineligible person or persons. Furthermore, I understand that if I intentionally misrepresented any of the information on the application, Blue KC and/or USABLE Life have the right to terminate or rescind coverage for that person or for all persons under the application; however no statement I make voids my coverage unless my statements are material to the risk assumed and contained in my written application. After my coverage has been in force for two (2) years from the effective date, no statement except fraudulent statements I make voids my medical or dental coverage or reduces my benefits. I understand that my medical records will be maintained with strict confidentiality by Blue KC and USABLE Life in accordance with applicable federal and state laws.

I authorize the bank selected by my Employer and Blue KC as the insurer of my high deductible health plan, and my Employer, if applicable, to exchange my enrollment status and other information necessary to establish my account, facilitate direct deposits to my account and accomplish other purposes related to payment for my healthcare, including complying with the terms of my depository agreement. I hold harmless and will indemnify the bank selected by my Employer and Blue KC for any claims against or losses the bank selected by my Employer and Blue KC may suffer arising out of the bank selected by my Employer and Blue KC's reliance on this authorization and release the bank selected by my Employer and Blue KC from all liability arising from such reliance.

EMPLOYEE'S SIGNATURE: _____ SPOUSE'S SIGNATURE: _____

PRINTED NAME: _____ PRINTED NAME: _____

DATE: _____ DATE: _____

Notices

NOTICE OF WOMEN'S HEALTH AND CANCER RIGHTS ACT:

Along with benefits detailed in your Certificate of Coverage 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.

SUMMARY OF BENEFITS AND COVERAGE NOTICE:

If you would like a copy of the Summary of Benefits and Coverage (SBC) for the product you are applying for, please see your employer for a copy. The SBC is available free of charge. SBCs are also available electronically at BlueKC.com. 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.