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

Kansas City

An Independent Licensee of the Blue Cross and Blue Shield Association

USAble Life

Group Application

GROUPS WITH 2 TO 99 FULL TIME EMPLOYEES

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

Preferred-Care Blue PPO | **Blue-Care HMO**

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. TAX ID NO.** (INCLUDE A # FOR EACH SUBSIDIARY)
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)

19. ARE ANY EMPLOYEES OF ANY SUBSIDIARY OR AFFILIATED COMPANIES TO BE COVERED UNDER THIS PLAN?

☐ YES ☐ NO (If yes, complete information) **Company Name(s)** _____ **No. of Employees** _____

Address _____ **City** _____ **State** _____ **Zip** _____ **County** _____

II Coverage Selection: Medical and Dental

20. APPLICATION FOR

Medical Coverage ***Select 1 Package Only***

☐ Package A ☐ Package B ☐ Package C ☐ Package D ☐ Package E ☐ Blue KC Exchange

(Select one for Package A, B, or C)

☐ Health Reimbursement Arrangement (HRA)

☐ High Deductible Health Plan (HDHP)

☐ Health Savings Account (HSA)*

* Do you plan to establish a relationship with a Blue KC preferred bank if electing an HSA offering? ☐ YES ☐ NO

Dental Coverage

(Choose to offer your employees either Group Dental or Voluntary Dental by selecting one plan below)

Group Dental

☐ BlueDental (Type I, II) 80/80

☐ BlueDental Plus (Type I, II, III) 100/80/50

☐ BlueDental Preferred (Type I, II, III, IV) 100/80/50/50

OR

Voluntary Group Dental

☐ BlueDental (VGD) (Type I, II) 80/80

☐ BlueDental Plus (VGD) (Type I, II, III) 100/80/50

☐ BlueDental Select (VGD) (Type I, II, III) 80/60/50

21. ADDITIONAL STATE MANDATED OPTIONS (if unmarked, assume offers rejected)

Does the company wish to purchase additional state mandated option? (additional premium may be required)

Speech and Hearing Disorders: ☐ Reject ☐ Accept

Pregnancy Terminations: ☐ Reject ☐ Accept

Child Health Supervision Services: ☐ Reject ☐ Accept

III USAble Life Insurance Information

22. Life Coverage ***Select 1 Package Only***

☐ Life Package 1 ☐ Life Package 2 ☐ Life Package 3 ☐ Life Package 4 ☐ Other _____

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 and provided that is the enrollees are to contribute to the cost of the insurance, 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 is not approved, no insurance shall become effective and any advance payment 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.

LAST NAME _____ **FIRST NAME** _____

IV Eligibility/Participation/Contribution/Medicare Secondary Payer

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

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

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

26. Effective date for new employees and their dependent(s) is: (NOTE: Kansas has a maximum of 90 days)
First of the month following the completion of ☐ 30 day ☐ 60 day ☐ 90 day ☐ Other: _____ day waiting period

27. List all employee classes eligible for coverage – Note: Groups with 50 or fewer employees must offer coverage to all employee classes (Ex. Manager, Salaried, Hourly, etc.)

28. For Missouri Groups with 2-50 employees, full-time is defined as working at least 30 hours per week. For all Kansas Groups (with 2-99 employees) and Missouri Groups with 51+ employees, number of hours considered full-time: _____ hours per week

29. Total number of full-time employees: _____ Total number of part-time employees: _____

30. Total number of eligible employees applying: _____

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

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

33. Are there any employees/dependents on Continuation of Coverage/COBRA? ☐ YES ☐ NO If yes, please list names:

34. Employer Contribution (either in percentage or dollar amounts)

Applicable to Packages A-E only
Minimum of 50% is required for employee.
Dollar minimum must be at least 25% of total premium.

BLUE KC EXCHANGE	_____ Employee	_____ Emp/Spouse	_____ Emp/Child(ren)	_____ Family
MEDICAL	_____ Employee	_____ Dependent		
DENTAL	_____ Employee	_____ Dependent		
LIFE/AD&D	_____ Employee	_____ Dependent Life		
SHORT TERM DISABILITY	_____ Employee			
LONG TERM DISABILITY	_____ Employee			

V 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 BCBSKC. The Company agrees to provide the documentation requested by insurer, which establishes that, all eligibility, underwriting 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. If you are a Missouri company with 2-50 employees, you represent that all employees working at least 30 hours per week will be offered 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: (1) renewal rates will be based on several factors which will include, but will not be limited to, the projected future claims experience of your group, except where prohibited by law; (2) 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.

BCBSKC reserves the right to retroactively change the premium rates to reflect the Company's or any Covered Person's accurate Medicare Secondary Payor information.

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

Employer Signature _____ Date _____/_____/_____

Title _____ Amount of deposit $ _____

Agent Information

AGENT NAME (PLEASE PRINT)	AGENT NUMBER		
PHONE NUMBER			
AGENCY NAME			
AGENT OFFICE CONTACT E-MAIL			

Blue KC Office Use Only

COMMISSION ARRANGEMENT HEALTH AND DENTAL		APPROVAL OF NON-STANDARD FULL-TIME STATUS: ☐ YES ☐ NO UNDERWRITING INITIALS: _____
COMMISSION ARRANGEMENT LIFE		
BLUE KC GROUP NUMBER	BLUE KC PARENT NUMBER	
SALES REP NUMBER	RISK CLASS	

AGENT SIGNATURE _____ DATE _____/_____/_____

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.

The coverage You have applied for includes contraceptive coverage (i.e. prescriptions, devices, implants, and/or elective sterilization).

You have a right under Missouri State law to exclude coverage for contraceptives due to Your moral, ethical, or religious beliefs. In addition, Your Employees have a right under Missouri State law to exclude coverage for contraceptives due to their moral, ethical, or religious beliefs.

The coverage You have applied for does not include elective pregnancy termination coverage.