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

Kansas City

An Independent Licensee of the Blue Cross and Blue Shield Association

Employee Dental and Life Application Form

USAble Life

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

GROUPS WITH 1 TO 100 EMPLOYEES

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

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 ☐ Adoption/Placement ☐ Reaching Lifetime Benefit Maximum
☐ Loss of Minimum Essential Coverage (except for termination due to non-payment of premium or termination for cause)
☐ Change of Beneficiary ☐ Other (Please call Customer Service at 888-989-8842).

I Employee Information Only

1. LAST NAME	**FIRST NAME**	**M.I.**	**2. STREET ADDRESS**

3. CITY	**STATE**	**ZIP CODE**	**4. HOME PHONE NO.** **WORK PHONE NO.**

5. GENDER ☐ Male ☐ Female	**6. SOCIAL SECURITY NO.**	**7. BIRTH DATE**

8. COMPANY NAME	**9. HIRE DATE**	**10. HOURS WORKED PER WEEK**

11. E-MAIL ADDRESS *Blue KC may use this e-mail address to provide documents, materials, and other notices related to this coverage.*

II 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.	GENDER	DATE OF BIRTH
☐ **New** ☐ **Change**	EMPLOYEE				☐ 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 Ancillary Coverage Selection

15. Dental Coverage Type *If desired, select only one coverage group. Product availability is limited to your Employer's selections.*
☐ Self ☐ Self + Spouse ☐ Self + Child(ren) ☐ Self + Family
If your Employer has elected to offer a buy-up plan, select either base plan or buy-up plan. If no selection is made, the base plan will be the default plan chosen.
☐ Base plan ☐ Buy-up plan *(I understand that selecting this option may increase my premium.)*

16. Life Coverage Type *Life coverage is available only for Employees who work an average of 25 hours a week or more. If Life coverage is desired, select "Yes." Product availability is limited to your Employer's selections. Employer may or may not be providing all premium contribution amounts for Life coverage. If you decline USAble 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.*
☐ Yes *(I understand that selecting this option may require premium contributions for Life coverage on my part.*
☐ No. *(I choose to waive all Life coverage and do not want to make premium contributions for Life coverage if Employer is not providing the full premium contribution amount.)*

LAST NAME _____ **FIRST NAME** _____

IV Other Health Insurance Carrier (for Coordination of Benefits)

17. On the day the coverage begins, will any family members be covered by other health or dental insurance, 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	INSURANCE COMPANY NAME	(AREA CODE) PHONE NO.
☐ Medical Insurance ☐ Dental Insurance		

NAME OF INSURED	INSURED'S EMPLOYER NAME	POLICY NO.

FAMILY MEMBERS COVERED

1. 2. 3.

18. 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

19. 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:

V 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	PERCENT-AGE

Total must equal 100% = 0

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

NAME (LAST, FIRST, M.I.)	ADDRESS	SOCIAL SECURITY NO.	BIRTHDATE	RELATIONSHIP	PERCENT-AGE

(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% = 0

LAST NAME _____ **FIRST NAME** _____

VI Agreement and Acknowledgment

I request coverage under the Group Contract(s) ("Contract") issued by Blue Cross and Blue Shield of Kansas City ("Blue KC") 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 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. 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.

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 or that if I made a material misrepresentation of a material fact about any person contained herein, 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.

EMPLOYEE'S SIGNATURE: _____

PRINTED NAME: _____

DATE: _____