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

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.

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 _____

20. DOES BLUE KC CURRENTLY PROVIDE OR ADMINISTER YOUR COMPANY'S HEALTH INSURANCE COVERAGE? ☐ YES ☐ NO

If "Yes," please provide your group number: _____

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

III Coverage Selection: Dental

21. Application for Dental Coverage *Choose to offer your employees Dental coverage by selecting one plan. Standard plan details may not be a complete description of all plan features. Buy-up options are not yet available. 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 - Preferred-Care

No.	Blue Dental (Type I / Type II)	$50 Individual Deductible / $150 Family Deductible	Buy-Up Plan
1	☐ 80% Type I / 80% Type II	$1,000 Calendar Year Maximum	Not available
2	☐ 80% Type I / 80% Type II	$1,500 Calendar Year Maximum	Not available
3	☐ 100% Type I / 80% Type II	$1,000 Calendar Year Maximum	Not available
4	☐ 100% Type I / 80% Type II	$1,500 Calendar Year Maximum	Not available
	Blue Dental Plus (Type I / Type II / Type III)	**$50 Individual Deductible / $150 Family Deductible**	
5	☐ 100% Type I / 80% Type II / 50% Type III	$1,000 Calendar Year Maximum	Not available
6	☐ 100% Type I / 80% Type II / 50% Type III	$1,500 Calendar Year Maximum	Not available
7	☐ 100% Type I / 90% Type II / 60% Type III	$1,000 Calendar Year Maximum	Not available
8	☐ 100% Type I / 90% Type II / 60% Type III	$1,500 Calendar Year Maximum	Not available
	Blue Dental Preferred (Type I / Type II / Type III / Type IV)	**$50 Individual Deductible / $150 Family Deductible With Orthodontics $1,000 Lifetime Maximum**	
9	☐ 100% Type I / 80% Type II / 50% Type III / 50% Type IV	$1,000 Calendar Year Maximum	Not available
10	☐ 100% Type I / 80% Type II / 50% Type III / 50% Type IV	$1,500 Calendar Year Maximum	Not available
11	☐ 100% Type I / 90% Type II / 60% Type III / 50% Type IV	$1,000 Calendar Year Maximum	Not available
12	☐ 100% Type I / 90% Type II / 60% Type III / 50% Type IV	$1,500 Calendar Year Maximum	Not available

Voluntary Group Dental - Preferred-Care

No.	Blue Dental (Type I / Type II)	$50 Individual Deductible / $150 Family Deductible	Buy-Up Plan
13	☐ 80% Type I / 80% Type II	$1,000 Calendar Year Maximum	Not available
14	☐ 100% Type I / 80% Type II	$1,000 Calendar Year Maximum	Not available
	Blue Dental Plus (Type I / Type II / Type III)	**$50 Individual Deductible / $150 Family Deductible**	
15	☐ 100% Type I / 80% Type II / 50% Type III	$1,000 Calendar Year Maximum	Not available
16	☐ 100% Type I / 90% Type II / 60% Type III	$1,000 Calendar Year Maximum	Not available
	Blue Dental Preferred (Type I / Type II / Type III / Type IV)	**$50 Individual Deductible / $150 Family Deductible With Orthodontics $1,000 Lifetime Maximum**	
17	☐ 100% Type I / 80% Type II / 50% Type III / 50% Type IV	$1,000 Calendar Year Maximum	Not available
18	☐ 100% Type I / 90% Type II / 60% Type III / 50% Type IV	$1,000 Calendar Year Maximum	Not available

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

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

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

V USAble Life Insurance Information

31. APPLICATION FOR Life 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 816-360-1018.*

If you have 2 or more employees, you may select Packages 5 through 8.

☐ **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 Employee Long-Term Disability.	$500 Employee Long-Term Disability.	No Employee Long-Term Disability.	$1,000 Employee Long-Term Disability.

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.

☐ **Package 9**	☐ **Package 10**
$50,000 Life Employee	$50,000 Life Employee
No Employee Long-Term Disability.	$1,500 Employee Long-Term Disability.

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

33. 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.

34. Will any of 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		
☐ YES ☐ NO	Long-Term Disability		

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

VI USAble Life Insurance Information - Continued

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.

VII 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

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

Blue KC Office Use Only

COMMISSION ARRANGEMENT HEALTH	COMMISSION ARRANGEMENT DENTAL
COMMISSION ARRANGEMENT LIFE	
BLUE KC GROUP NUMBER	BLUE KC PARENT NUMBER
SALES REP NUMBER	RISK CLASS

AGENT SIGNATURE _____ DATE _____