EMPLOYER USE ONLY: BCBSKC GROUP NO. .... SUBGROUP NO. .... CLASS NO. ....

BlueCross BlueShield of Kansas City

An Independent Licensee of the Blue Cross and Blue Shield Association

Employee Application and Change Form

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

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

LAST NAME	FIRST NAME	M.I.	STREET ADDRESS

CITY	STATE	ZIP CODE	HOME PHONE NO. ( ) WORK PHONE NO. ( )

E-MAIL ADDRESS	BIRTH DATE	GENDER	SOCIAL SECURITY NO.
	/ /	☐ Male ☐ Female	– –

HIRE DATE	MARITAL STATUS	EMPLOYER	POSITION	NO. OF HRS WORKED PER WK
/ /	☐ Married ☐ Single			

II Medical Coverage Selection

I Elect Coverage For *(select only one)*

☐ **Preferred Provider Organization (PPO)** ☐ **AffordaBlue (PPO)** ☐ **HMO**

☐ Lower Deductible *(if applicable)*

☐ Higher Deductible *(if applicable)*

☐ High Deductible Health Plan (HDHP) *(if applicable)*

☐ **Health Reimbursement Arrangement (HRA)**

☐ **Health Savings Account (HSA)**

Would you like to set up an HSA with your Employer's preferred bank?

☐ *Yes* ☐ *No (if yes, please complete section IX)*

Medical *(select only one)* ☐ Self ☐ Self + Child(ren) ☐ Self + Spouse ☐ Self + Family

III Ancillary Coverage Selection

Dental *(select only one if offered)*

☐ Self ☐ Self + Child(ren)

☐ Self + Spouse ☐ Self + Family

Life *(some or all may be offered by your Employer)*

☐ Life/AD&D (See Section X) ☐ Supplemental Life (Supp Life)

☐ Dependent Life (Dep Life) $2.50 *(Payable to Employee only)*

☐ Short Term Disability (STD) ☐ Long Term Disability (LTD)

☐ Waive (I choose to waive all Life products listed above)

IV Employee and Family Information - Employee and Employee's Dependents to be Enrolled: (Attach Sheet if Necessary)

SOCIAL SECURITY NO.	LAST NAME	FIRST NAME	M.I.	DATE OF BIRTH	GENDER	RELATION TO EMPLOYEE	TOBACCO USER	HEIGHT	WEIGHT	PRIMARY CARE PHYSICIAN (Complete Only If Applying For HMO Coverage)	CURRENT PATIENT
Employee – –				/ /	☐ Male ☐ Female		☐ YES ☐ NO			PCP Name: PCP NO.	☐ YES ☐ NO
Spouse – –				/ /	☐ Male ☐ Female		☐ YES ☐ NO			PCP Name: PCP NO.	☐ YES ☐ NO
Child – –				/ /	☐ Male ☐ Female	☐ Biological ☐ Step ☐ Adopted	☐ YES ☐ NO			PCP Name: PCP NO.	☐ YES ☐ NO
Child – –				/ /	☐ Male ☐ Female	☐ Biological ☐ Step ☐ Adopted	☐ YES ☐ NO			PCP Name: PCP NO.	☐ YES ☐ NO
Child – –				/ /	☐ Male ☐ Female	☐ Biological ☐ Step ☐ Adopted	☐ YES ☐ NO			PCP Name: PCP NO.	☐ YES ☐ NO

V Waiver of Coverage Selection

I Decline Coverage For:

Medical ☐ Self ☐ My Spouse ☐ My Dependent Child(ren)

Dental ☐ Self ☐ My Spouse ☐ My Dependent Child(ren)

Due To:

☐ Existence of Other Group Health Coverage ☐ Medicare or Medicaid

☐ Existence of Other Individual Health Coverage ☐ Other Reason (Explain) ....

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 and a preexisting condition exclusion period may apply. 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.

LAST NAME .... FIRST NAME ....

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: ☐ Medical Insurance ☐ Dental Insurance	INSURANCE COMPANY NAME	(AREA CODE) PHONE NO. ( )

NAME OF INSURED	INSURED'S EMPLOYER NAME	POLICY NO.

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: Date / /

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 Pre-Existing Conditions: If you are enrolling in the PPO product, please complete the following to receive Creditable Coverage

Your Employer's group contract provides coverage that may contain limitations based on whether a condition is considered preexisting. For Kansas groups and Kansas residents, any condition (whether physical or mental) for which medical advice, diagnosis, care or treatment was recommended or received within the 90 day period prior to the enrollment date is considered a preexisting condition, and your Employer's group contract excludes coverage for these specific preexisting conditions for 90 day from the enrollment date. For Missouri groups, any condition (whether physical or mental) for which medical advice, diagnosis, care or treatment was recommended or received within the 6 month period prior to the enrollment date is considered a preexisting condition, and your Employer's group contract excludes coverage for these specific preexisting conditions for 12 months from the enrollment date. However, your Employer's group contract will provide credit for preexisting conditions if you were previously covered under creditable coverage. The period of any preexisting condition exclusion that would otherwise apply to a person will be reduced by the number of days of creditable coverage the person has as of the enrollment date. In order to receive credit toward the preexisting condition exclusion period, you must provide copies of the Certificates of Creditable Coverage or other acceptable proof of coverage from the prior plan(s) or the following information for the verification of prior creditable medical coverage you or any listed dependents currently have, or previously had, including continuation of coverage. You have the right to request a Certificate of Creditable Coverage from your prior plan or insurer. To request assistance in obtaining a Certificate of Creditable Coverage from a prior plan or insurer, please contact Blue Cross and Blue Shield of Kansas City. Should you need additional information or assistance regarding any preexisting condition exclusion, please contact our Member Services Department at (816) 395-2950.

Insurance Company Name	Name as Listed on Policy	Name(s) of Person(s) Covered in Prior Plan	Effective Date	Termination Date
			/ /	/ /

VIII(a) All Questions Must Be Answered Before Your Application Will Be Processed

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 BEEN DIAGNOSED OR TREATED FOR ANY OF THE FOLLOWING CONDITIONS:

YES NO

1. ☐ ☐ Bone/Joint/Muscular Disorder/Joint Replacement
2. ☐ ☐ Arthritis/Gout/Back or Neck Disorder
3. ☐ ☐ Fibromyalgia/Chronic Fatigue Syndrome
4. ☐ ☐ Lupus - Type ________
5. ☐ ☐ Nervous System/Brain Disorder/Alzheimer's
6. ☐ ☐ Epilepsy/Seizure Disorder
7. ☐ ☐ Multiple Sclerosis
8. ☐ ☐ Parkinson's Disease
9. ☐ ☐ Heart/Circulatory Disorder
10. ☐ ☐ Stroke
11. ☐ ☐ High Blood Pressure
(Last reading ________ Date ________)
12. ☐ ☐ Blood Disorder/Leukemia/Hemophilia

YES NO

13. ☐ ☐ Elevated Cholesterol
(Last reading ________ Date ________)
14. ☐ ☐ Diabetes-Hemoglobin A1C
(Last reading ________ Date ________)
15. ☐ ☐ HIV/AIDS/AIDS Related Complex
16. ☐ ☐ Abnormal Pap Smear
(if yes, submit copies of last 2 pap smear results)
17. ☐ ☐ Infertility/Reproductive Disorder
18. ☐ ☐ Cancer - Type ________
19. ☐ ☐ Tumor/Cyst/Polyp
20. ☐ ☐ Respiratory/Lung Disorder/Asthma/Tuberculosis
21. ☐ ☐ Emphysema/Chronic Obstructive Pulmonary Disease
22. ☐ ☐ Pancreatic Disorder
23. ☐ ☐ Thyroid Disorder/Goiter

YES NO

24. ☐ ☐ Kidney/Bladder/Urinary Disorder
25. ☐ ☐ Liver Disorder/Hepatitis ☐A ☐B ☐C
26. ☐ ☐ Chiropractic Treatment - Number of Visits in Last 12 Months ________
27. ☐ ☐ Digestive/Intestinal Disorder
28. ☐ ☐ Crohn's Disease/Diverticulitis/Diverticulosis
29. ☐ ☐ Mental/Nervous Disorders
30. ☐ ☐ Schizophrenia/Manic-Depression/Suicide Attempt
31. ☐ ☐ Attention Deficit Disorder
32. ☐ ☐ Anorexia/Bulemia
33. ☐ ☐ Any Other Abnormality/Deformity/Birth Defect *(List all below)*
34. ☐ ☐ Glaucoma-Eye Pressure Readings
R ______ L ______
35. ☐ ☐ Eye Disorders/Cataracts

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

VIII(b) Additional Medical Information - List below full details to questions answered in section VIII(a): (Attach Sheet if Needed)

QUESTION NUMBER	PERSON TREATED	CONDITION & TYPE OF TREATMENT	DATE OCCURRED	LAST DATE OF TREATMENT	CURRENT STATUS	COMPLETE NAME & ADDRESS OF PROVIDER

LAST NAME .... FIRST NAME ....

VIII(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 complications or 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. 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? ________________

G. 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 ________________

H. 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 ________________

I. 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) ________________

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

Prescription Information (Attach Sheet if Necessary)

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

K. 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 ....

IX If you are enrolling in a BlueSaver PPO & 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 ACCOUNT.)*

| | | | — | | | — | | | | |

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

X If you are enrolling in Life Insurance, please complete the following: (Attach Sheet if Necessary)

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

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

Name (Last, First, MI)	Address	SSN	Birthdate	Relationship	Percentage
				Total must equal 100% =	

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

Name (Last, First, MI)	Address	SSN	Birthdate	Relationship	Percentage
				Total must equal 100% =	

Employee's Earnings Hourly .... Monthly .... Yearly ....

XI Agreement & Acknowledgment

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

With respect to my request for coverage under the Contract:
I understand that if at any time it is determined by BCBSKC or USAble Life that a person listed on this application did not meet the Contract's or Policy's definition of dependent, BCBSKC 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 misrepresented any of the information on the application, BCBSKC 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 BCBSKC and USAble Life in accordance with applicable federal and state laws. If electing a BlueSaver Plan, I acknowledge that this High Deductible Health Plan (HDHP) is for use with a Health Savings Account (HSA).

I authorize the bank selected by my Employer and BCBSKC 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 BCBSKC for any claims against or losses the bank selected by my Employer and BCBSKC may suffer arising out of the bank selected by my Employer and BCBSKC's reliance on this authorization and release the bank selected by my Employer and BCBSKC from all liability arising from such reliance.

EMPLOYEE'S SIGNATURE: .... SPOUSE'S SIGNATURE: ....

PRINTED NAME: .... PRINTED NAME: ....

DATE: .... DATE: ....

NOTICE OF WOMEN'S HEALTH AND CANCER RIGHTS ACT : Along with benefits detailed in your Certificate of Coverage, 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.