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 Application and Change Form

USAble Life

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

GROUPS WITH 100+ FULL TIME EMPLOYEES

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

Preferred-Care Blue PPO | Preferred-Care 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

I Employee Information Only

1. LAST NAME	FIRST NAME	MIDDLE INITIAL	2. STREET ADDRESS

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

5. E-MAIL ADDRESS *Blue KC may use this e-mail address to provide documents, materials, and other notices related to this coverage.*	6. BIRTH DATE	7. SOCIAL SECURITY NO.

8. HIRE DATE	9. EMPLOYER	POSITION	10. NO. OF HOURS WORKED PER WEEK

II Medical Coverage Selection

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

- ☐ Blue-Care (HMO) Option 1
- ☐ Blue-Care (HMO) Option 2
- ☐ Blue-Care (HMO) Option 3
- ☐ Preferred-Care (PPO)
- ☐ PersonalBlue (PPO) (Personal Care Account + PPO)
- ☐ Preferred-Care Blue (PPO) Option 1
- ☐ Preferred-Care Blue (PPO) Option 2
- ☐ Preferred-Care Blue (PPO) Option 3
- ☐ Preferred-Care Blue (PPO) BlueSaver ‡ (High deductible health plan (HDHP) for use with an HSA)

‡ *Would you like to set up an HSA with your Employer's preferred bank?*
☐ *YES* ☐ *NO*
(if Yes, please complete section VII)

Medical Plan Design Choice *(Select only one. If no selection is made, employee will be enrolled in Base Plan)*

☐ Base Plan ☐ Buy-Up Plan (I understand this election may increase my employee contributions)

III Ancillary Coverage Selection

Dental *(If offered by your Employer.)*

- ☐ Preferred-Care Dental PPO
- ☐ Traditional

Life *(If offered, through USAble Life.)*

- ☐ Life/AD&D (See Section VIII)
- ☐ Dependent Life (Dep Life) $2.50 (Payable to Employee only.)
- ☐ Short Term Disability (STD)
- ☐ Long Term Disability (LTD)
- ☐ Supplemental Life (Supp Life)
- ☐ Waive (I choose to waive all Life products listed above.)

* Good Health HMO, Inc. d/b/a Blue Care

LAST NAME _____ **FIRST NAME** _____

IV 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
☐ **New** ☐ **Change**	EMPLOYEE			☐ Male ☐ Female	☐ Medical ☐ Dental	PCP Name: PCP No.:	☐ Yes ☐ No
☐ **New** ☐ **Change**	SPOUSE			☐ Male ☐ Female	☐ Medical ☐ Dental	PCP Name: PCP No.:	☐ Yes ☐ No
☐ **New** ☐ **Change**	CHILD			☐ Male ☐ Female	☐ Medical ☐ Dental	PCP Name: PCP No.:	☐ Yes ☐ No
☐ **New** ☐ **Change**	CHILD			☐ Male ☐ Female	☐ Medical ☐ Dental	PCP Name: PCP No.:	☐ Yes ☐ No
☐ **New** ☐ **Change**	CHILD			☐ Male ☐ Female	☐ Medical ☐ Dental	PCP Name: PCP No.:	☐ Yes ☐ No

V Waiver of Coverage Selection

If Waiving Coverage, Information Will Appear on the Following Page(s)

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.

Employee Name: ____________________________ SSN: _________________________________

Check Appropriate Box	Social Security Number	Name	Birth	Gender	Indicate Coverage	Primary Care Physician	Current Patient
New Change	Child			☐ Male ☐ Female	☐ Medical ☐ Dental	PCP Name PCP No.	☐ Yes ☐ No
New Change	Child			☐ Male ☐ Female	☐ Medical ☐ Dental	PCP Name PCP No.	☐ Yes ☐ No
New Change	Child			☐ Male ☐ Female	☐ Medical ☐ Dental	PCP Name PCP No.	☐ Yes ☐ No
New Change	Child			☐ Male ☐ Female	☐ Medical ☐ Dental	PCP Name PCP No.	☐ Yes ☐ No
New Change	Child			☐ Male ☐ Female	☐ Medical ☐ Dental	PCP Name PCP No.	☐ Yes ☐ No
New Change	Child			☐ Male ☐ Female	☐ Medical ☐ Dental	PCP Name PCP No.	☐ Yes ☐ No
New Change	Child			☐ Male ☐ Female	☐ Medical ☐ Dental	PCP Name PCP No.	☐ Yes ☐ No
New Change	Child			☐ Male ☐ Female	☐ Medical ☐ Dental	PCP Name PCP No.	☐ Yes ☐ No
New Change	Child			☐ Male ☐ Female	☐ Medical ☐ Dental	PCP Name PCP No.	☐ Yes ☐ No
New Change	Child			☐ Male ☐ Female	☐ Medical ☐ Dental	PCP Name PCP No.	☐ Yes ☐ No
New Change	Child			☐ Male ☐ Female	☐ Medical ☐ Dental	PCP Name PCP No.	☐ Yes ☐ No
New Change	Child			☐ Male ☐ Female	☐ Medical ☐ Dental	PCP Name PCP No.	☐ Yes ☐ No
New Change	Child			☐ Male ☐ Female	☐ Medical ☐ Dental	PCP Name PCP No.	☐ Yes ☐ No
New Change	Child			☐ Male ☐ Female	☐ Medical ☐ Dental	PCP Name PCP No.	☐ Yes ☐ No
New Change	Child			☐ Male ☐ Female	☐ Medical ☐ Dental	PCP Name PCP No.	☐ Yes ☐ No
New Change	Child			☐ Male ☐ Female	☐ Medical ☐ Dental	PCP Name PCP No.	☐ Yes ☐ No

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	INSURANCE COMPANY NAME (AREA CODE) PHONE NO.	POLICY NO.
□ Medical Insurance □ Dental Insurance		

NAME OF INSURED	INSURED'S EMPLOYER NAME	EFFECTIVE DATE	TERMINATION DATE

FAMILY MEMBERS COVERED

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 If You Are Enrolling in a BlueSaver PPO 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)*

VIII 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% =

LAST NAME _____ FIRST NAME _____

IX(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?:

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 _____ _____
35. ☐ ☐ Eye Disorders/Cataracts

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

_____

_____

_____

_____

IX(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

If Medical Information Has Been Entered It Will Appear on the Following Page(s)

LAST NAME FIRST NAME

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

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:
							SS:
							ADDRESS:
							NAME: ADDRESS:

If Medical Information Has Been Entered It Will Appear on the Following Page(s)

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 _____

LAST NAME _____ **FIRST NAME** _____

Medical Questionnaire Continued (attach sheet if necessary)

ANY ADDITIONAL INFORMATION

If Medical Information Has Been Entered It Will Appear on the Following Page(s)

LAST NAME _____ **FIRST NAME** _____

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 Inc. 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.