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

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

GROUPS WITH 100+ EMPLOYEES

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

Preferred-Care Blue **BlueSelect Plus** **Preferred-Care Blue-Care***

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 all options that may apply. More than one pharmacy network may be selected for multiple products. More than one medical network may be selected for a single product. If Employer has employees who reside outside of the BlueSelect Plus Service Area and contiguous counties, Employer must select an additional network option.* ***Applies to Missouri employers only:*** *If Basic products are offered, a non-Basic product must also be offered. Benefits are limited to services provided by Preferred Providers, except for Emergency Services and certain Mental Health office visits. Services provided by Non-Preferred Providers are not covered, except as specifically provided. Covered Services for certain Mental Health office visits include 2 office visits per Calendar Year for the diagnosis or assessment of Mental Illness to a Non-Preferred Provider acting within the scope of their license.:*

Medical Networks	Pharmacy Networks	Product/Plan Types
☐ Preferred-Care Blue	☐ National Plus (NP)	☐ Copay PPO ☐ Copay EPO
☐ Preferred-Care	☐ Walgreens Advantage (WAN)	☐ Affordablue PPO ☐ Affordablue EPO
☐ BlueSelect Plus	☐ Tiered Express Advantage (EAN)/NP	☐ Traditional PPO ☐ Traditional EPO
☐ Blue-Care		☐ BlueValue PPO ☐ BlueValue EPO
		☐ PersonalBlue HRA+PPO ☐ PersonalBlue HRA+EPO
		☐ Spira PPO ☐ Spira EPO
		☐ Basic PPO ☐ Basic EPO
		☐ BlueSaver* PPO ☐ BlueSaver* EPO
		* High Deductible Plan for use with a Health Savings Account (HSA). Do you plan to establish a relationship with a Blue KC preferred bank if electing an HSA offering? ☐ YES ☐ NO
		☐ Blue-Care HMO ☐ RateSaver HMO

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

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III Coverage Selection: Dental and Vision

21. APPLICATION FOR Dental Coverage *Choose to offer your employees Dental coverage by selecting plan type(s) and products below.*

Plan Type	**Networks** *(select PPO or Choice, or combined PPO and Choice)*
☐ Group Dental ☐ Voluntary Group Dental	☐ BlueDental PPO/Choice ☐ BlueDental PPO ☐ BlueDental Choice

22. APPLICATION FOR Vision Coverage *Select up to a maximum of only two (2) products.*

☐ Blue Vue Base	☐ Blue Vue 0/130	☐ Blue Vue 0/150	☐ Blue Vue 0/200
☐ Blue Vue 10/100	☐ Blue Vue 10/130	☐ Blue Vue 10/150	☐ Blue Vue 10/200

IV Underwriting Questionnaire

23. Are any dependent children age 26 or over who might be considered developmentally disabled or physically handicapped?
☐ YES ☐ NO If YES, please give name and medical condition (attach additional sheet if necessary):

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

25. Total number of employees: _____ Full-time: _____ Part-time: _____

26. Total number of eligible employees: _____

27. Effective date for new employees and their dependent(s) is:

☐ First of the month immediately following or coincident with satisfying the eligibility waiting period (if any).

☐ Immediately upon satisfying the eligibility waiting period (if any).

First of the month following the completion of ☐ 30 day ☐ 60 day ☐ Other waiting period

28. Is anyone currently disabled, confined at home, incapacitated, or confined in a hospital treatment facility, or otherwise not at work?
☐ YES ☐ NO If YES, please give name and medical conditions (attach additional sheet if necessary):

29. Are there any employees/dependents on Continuation of Coverage/COBRA? ☐ YES ☐ NO If YES, please list names (attach additional sheet if necessary):

30. Are any employees, dependents or COBRA participants: disabled, pregnant or receiving fertility treatment; been hospitalized or had claims in excess of $10,000 in the past 12 months; ever had or been treated for a mental/nervous disorder; tested positive for, or treated for the AIDS virus or ARC? If so, give name, date and medical conditions (if known or available). Attach additional page if necessary.

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

MEDICAL	_____	Employee	_____	Dependent
DENTAL	_____	Employee	_____	Dependent
VISION	_____	Employee	_____	Dependent

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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. Company agrees to provide the documentation requested by Blue Cross and Blue Shield of Kansas City and Good Health HMO, Inc. d/b/a Blue-Care (collectively, "Blue KC"), which establishes that all eligibility, underwriting, and participation requirements of the Group Contract are met. Company agrees that providing incomplete, inaccurate, or untimely information may affect individual's or group's coverage or may effect the rates. Company shall notify Blue KC 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. Blue KC shall be entitled to rely on the most current information in its possession regarding eligibility of employees and their dependents in providing coverage. Blue KC reserves the right to retroactively change the premium rates to reflect the Company's or covered person's accurate Medicare Secondary Payer information.

During and after termination of the Group Contract, Company grants Blue KC permission to use and/or transfer to third parties for research and analysis purposes the claims and related medical data in Blue KC'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 Blue KC after the application has been approved by Blue KC and after the first full premium has been paid. The Company's cancelled 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.

To avoid processing delays, make sure you:

1. Answer all questions completely and accurately.
2. DO NOT CANCEL YOUR EXISTING COVERAGE UNTIL YOU RECEIVE WRITTEN NOTIFICATION OF APPROVAL.
3. Submit the most recent billing statement listing those currently insured and current rates (required only if this plan is replacing an existing plan of insurance). If no previous carrier, please submit last quarterly wage and tax statement if required by underwriting.
4. Have employees selecting a PPO plan or Basic plan attach their most recent Explanations of Benefits to their application for deductible credit.

Employer Signature _____ Date _____/_____/_____

Title _____ Amount of deposit $ _____

Agent Information		**Blue KC Office Use Only**	
AGENT NAME (PLEASE PRINT)	AGENT NUMBER	COMMISSION ARRANGEMENT HEALTH	
PHONE NUMBER		COMMISSION ARRANGEMENT DENTAL	
AGENCY NAME		BLUE KC GROUP NUMBER	BLUE KC PARENT NUMBER
AGENT OFFICE CONTACT E-MAIL		SALES REP NUMBER	RISK CLASS

AGENT SIGNATURE _____ DATE _____

Notices

SUMMARY OF BENEFITS AND COVERAGE

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 1-816-395-3558. 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 health plan's coverage does not include an elective pregnancy termination benefit.