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

Kansas City

An Independent Licensee of the Blue Cross and Blue Shield Association

USAble Life

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	MIDDLE INITIAL	STREET ADDRESS	
CITY	STATE	ZIP CODE	HOME PHONE NO. ( )	
			WORK PHONE NO. ( )	
E-MAIL ADDRESS		BIRTH DATE / /	GENDER ☐ Male ☐ Female	SOCIAL SECURITY NO. - -
HIRE DATE / /	MARITAL STATUS ☐ Married ☐ Single	EMPLOYER	POSITION	NO. OF HOURS WORKED PER WEEK

II Medical Coverage Selection

I Elect Coverage For (select only one)

Preferred-Care Blue (PPO) ☐ $300 ☐ $500 ☐ $1,000 ☐ $1,500 ☐ $2,000 ☐ $3,500

AffordaBlue (PPO) ☐ $2,500 ☐ $5,000

High Deductible Health Plan (HDHP) ☐ $2,000 ☐ $2,500 ☐ $5,000

PersonalBlue Health Reimbursement Arrangement (HRA) ☐ $2,000 ☐ $2,500 ☐ $5,000

BlueSaver (For use with an HSA) ☐ $2,000 ☐ $2,500 ☐ $5,000

An HSA will be established unless you indicate otherwise. Please complete section IX.

☐ No, I do not want to open an HSA

☐ HMO

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)

☐ Dependent Life (Dep Life)

☐ Short Term Disability (STD)

☐ Long Term Disability (LTD)

☐ Supplemental Life

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

IV Employee Information Only - 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	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.

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 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

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 thte 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 forms, even if the disease ro 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 R _____ L _____
35. ☐ ☐ Eye Disorders/Cataracts

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

LAST NAME _____ FIRST NAME _____

VIII(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

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 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 AND 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 _____

LAST NAME _____ FIRST NAME _____

Medical Questionnaire Continued (attach sheet if necessary)

ANY ADDITIONAL INFORMATION

IX If You Are Enrolling in BlueSaver PPO and an HSA Will be Established, 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)

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, 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
		- -	/ /		
		- -	/ /		

Employee's Earnings Hourly _____ Monthly _____ Yearly _____ Total must equal 100% =

XI 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 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. 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 hereby authorize any physician, medical practitioner, hospital, clinic, veterans administration facility, pharmacy or pharmacy-related facility; insurance company, reinsurer or consumer reporting agency to give to Company any information regarding diagnosis, treatment and prognosis with respect to any physical, mental or dental condition or any other information pertaining to employment or other medical insurance for me or any member of my family shown on this enrollment form, including any information for which I or a member of my family requested a self-pay restriction from the provider. I further authorize Company to disclose such information to any third parties utilized to provide services or benefits relating to my insurance contract; or any request for such information which Company is legally required to provide. I understand that this authorization is a condition of my enrollment in a Blue KC health plan or eligibility for benefits, and that by not signing this authorization Blue KC may decline to enroll me or to give me benefits. I understand that I may revoke this authorization, in writing; however, any information already used or relied on by Blue KC will not be affected by my revocation. I agree that, unless revoked by me in writing, this authorization shall remain valid for two (2) years from the date signed and that a photocopy of this authorization will be as valid as the original.

LAST NAME _____ FIRST NAME _____

With respect to my request for coverage under the Contract:

I understand that if at any time it is determined by BlueKC 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. If electing a BlueSaver Plan, I acknowledge that this High Deductible Health Plan (HDHP) is for use with a Health Savings Account (HSA) and I have received the HSA Terms and Conditions.

I authorize the bank 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 and Blue KC for any claims against or losses the bank and Blue KC may suffer arising out of the bank and Blue KC's reliance on this authorization and release the bank and Blue KC 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.

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.

The coverage You have applied for includes contraceptive coverage (i.e. prescriptions, devices, implants, and/or elective sterilization).

For Missouri residents and Missouri groups only, You have a right under Missouri State law to exclude coverage for contraceptives. If You desire to exclude coverage for contraceptives, please call Our Customer Service Department for information on how to make this election.

The coverage You have applied for does not include elective pregnancy termination coverage.