



BlueCross BlueShield
of Kansas City
An Independent Licensee of the
Blue Cross and Blue Shield Association

Employee Application & Change Form

Preferred-Care PPO
Preferred-Care Blue PPO
Blue-Care HMO

Please complete all boxes legibly (print)
in blue or black ink and sign.

If application is to be used as a Change Form, please specify event below: (Date of Event: _____)

- Birth Address Divorce Marriage
 Death Adoption/Placement Loss of other group coverage

Employer Use Only: BCBSKC Group No. _____ SubGroup No. _____ Class No. _____

I - Employee Information

| | | | | | | | | | | |
|--|--|----------------------|---------|-----------------------|---------------------------|------------------|-------------|-------------------------------------|----------------------|--|
| 1. Last Name | | First Name | | M.I. | 2. Social Security Number | | | | | |
| 3. Street Address | | | 4. City | | 5. State | | 6. Zip Code | | 7. Birthdate / / | |
| 8. Marital Status / Sex <input type="checkbox"/> Married <input type="checkbox"/> M <input type="checkbox"/> Single <input type="checkbox"/> F | | 9. Home Phone () | | 10. Work Phone () | | 11. Company Name | | | 12. Hire Date / / | |
| 13. E-mail address | | | | | 14. Position | | | 15. Number of Hours Worked Per Week | | |

II - Family Information - Employee and dependents to be enrolled or changed: (Attach sheet if necessary)

| Check Appropriate Box | Employee/Dependent Social Sec. No. | Last Name | First Name | M.I. | Birthdate | Indicate Coverage | Sex | Primary Care Physician- Complete only for HMO | Current Patient |
|-----------------------|------------------------------------|-----------|------------|------|-----------|---|--|---|---|
| New | | EMPLOYEE | | | | <input type="checkbox"/> Medical <input type="checkbox"/> Dental | <input type="checkbox"/> M <input type="checkbox"/> F | PCP Name: PCP No: | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Change | | SPOUSE | | | | <input type="checkbox"/> Medical <input type="checkbox"/> Dental | <input type="checkbox"/> M <input type="checkbox"/> F | PCP Name: PCP No: | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| New | | CHILD | | | | <input type="checkbox"/> Medical <input type="checkbox"/> Dental | <input type="checkbox"/> M <input type="checkbox"/> F | PCP Name: PCP No: | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Change | | CHILD | | | | <input type="checkbox"/> Medical <input type="checkbox"/> Dental | <input type="checkbox"/> M <input type="checkbox"/> F | PCP Name: PCP No: | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| New | | CHILD | | | | <input type="checkbox"/> Medical <input type="checkbox"/> Dental | <input type="checkbox"/> M <input type="checkbox"/> F | PCP Name: PCP No: | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Change | | CHILD | | | | <input type="checkbox"/> Medical <input type="checkbox"/> Dental | <input type="checkbox"/> M <input type="checkbox"/> F | PCP Name: PCP No: | <input type="checkbox"/> Yes <input type="checkbox"/> No |

If Dependent Child(ren) are full-time Students in College, Vocational or Trade School, please indicate name of school & dependent Child's Name (Full-time students may not be eligible Dependents under your group coverage).

1. _____ 2. _____

III - Coverage Selection

Proposed Effective Date: ____ / ____ / ____

Medical (Select only one)

- Blue-Care (HMO) Option 1 Blue-Care (HMO) Option 2 Blue-Care (HMO) Option 3 Preferred-Care (PPO)
 Preferred-Care Blue (PPO) Option 1 Preferred-Care Blue (PPO) Option 2 Preferred-Care Blue (PPO) Option 3
 BlueSaver High Deductible PPO Plan for use with an HSA ‡ PersonalBlue (Personal Care Account + PPO)

‡ Would you like to set up an HSA with your Employer's preferred bank? Yes No

Dental (if Offered)

- Preferred-Care Dental (PPO) Traditional

IV - Declination of Coverage Selection

Must complete to decline MEDICAL or DENTAL coverage

I decline to enroll for coverage for: myself my spouse my dependent child(ren)

Due to: Existence of other group health coverage Existence of other individual health coverage, including Medicare and Medicaid
 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 new dependent(s), provided that you request enrollment within 31 days after a marriage, birth, adoption or placement for adoption. 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 pre-existing condition exclusion period may apply. To request a special enrollment, please contact our Member Services Department at (816) 395-2950.

V - Preexisting Conditions - Prior Coverage - PPO Only

Your Employer's group contract provides coverage that may contain limitations based on whether a condition is considered preexisting. Please consult the Health Benefit Plan Summary provided to you for specific information on preexisting conditions and the length any preexisting condition exclusion period. Your Employer's group contract will provide credit for pre-existing 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 towards the pre-existing condition exclusion period,

V – Preexisting Conditions – Prior Coverage – PPO Only Continued

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 Covered in Prior Plan | Effective Date / / |
| | | | Termination Date / / |

VI – Other Health Insurance Information (For Coordination of Benefits) STOP! This section must be completed or application will be returned.

On the day the coverage begins will any family members be covered by other health or dental insurance or Medicare, including continuation of coverage? NO YES If yes, answer all questions below. Use extra paper if more than one additional policy will be in force.

| | |
|---|--|
| Coverage type: <input type="checkbox"/> Medical Insurance <input type="checkbox"/> Dental Insurance | Insurance Company Name and (Area Code) Phone Number () |
|---|--|

| | | |
|-----------------|-------------------------|---------------|
| Name of Insured | Insured's Employer Name | Policy Number |
|-----------------|-------------------------|---------------|

Family Members Covered

1. _____ 2. _____ 3. _____

If coverage for any of your dependent children is subject to a divorce decree or court order, whose coverage is primary? Yours The Other Parent's

VII - If You or Your Dependent have Medicare, please complete the following:

If you or your dependent have Medicare, include a copy of your Medicare card(s) with this Application.

If you or your spouse have Medicare and are actively working, check appropriate box: You Spouse

If you or your spouse are retired, please provide date of retirement: You _____ Your Spouse _____

VIII - 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.)

IX – Agreement & Acknowledgment

I request coverage under the Group Contract ("Contract") issued by Blue Cross and Blue Shield of Kansas City ("BCBSKC") and Subsidiaries. I authorize my Employer to deduct from my earnings any required contributions. I understand services will be available subject to the exclusions, limitations, and benefits described in the Contract. **I understand that if it is determined by BCBSKC that a person listed on this application did not meet the Contract's definition of dependent, or I misrepresented any of the information contained herein; BCBSKC and/or its subsidiaries have the right to cancel or rescind coverage for that person or for all persons under the application, and to recover any benefit payments for such ineligible person or persons.** I understand no statement I make voids my coverage or reduces my benefits after my coverage has been in force for two (2) years from the effective date, unless my statements are material to the risk assumed and contained in my written application. I understand that my medical records will be maintained with strict confidentiality by BCBSKC in accordance with applicable federal and state laws. I acknowledge that I have received a Health Benefit Plan Summary that contains information regarding preexisting condition and preexisting condition exclusion periods.

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.

The translation is for informational purposes only; and the English version will be controlling unless the language in the other language version is shown to be a fraudulent misrepresentation.

La traducción está para el propósito informativo solamente; y la versión inglesa controlará a menos que la lengua en la otraversión de la lengua se demuestre para ser una mala representación fraudulenta.

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 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.