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

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 | BlueSelect Plus 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 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	HEIGHT	WEIGHT	INDICATE COVERAGE	PRIMARY CARE PHYSICIAN (Complete only if applying for HMO)	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
New Change	CHILD			☐ Male ☐ Female			☐ Medical ☐ Dental	PCP Name: PCP No.:	☐ Yes ☐ No

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

LAST NAME _____ **FIRST NAME** _____

III Waiver of Coverage Selection

I Decline Coverage For	**Due to:**
Medical □ Self □ My Spouse □ My Dependent Child(ren)	□ Existence of Other Group Health Coverage
Dental □ Self □ My Spouse □ My Dependent Child(ren)	□ Existence of Other Individual Health Coverage
	□ Medicare or 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 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. To request a special enrollment for medical and/or dental coverage, please contact our Member Services Department at (816) 395-2950.

IV Medical Coverage Selection

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

Preferred-Care Blue PPO	**BlueSelect Plus PPO**	**Preferred-Care PPO**
□ Preferred-Care Blue 1	□ BlueSelect Plus Option 1	□ Preferred-Care Option 1
□ Preferred-Care Blue 2	□ BlueSelect Plus Option 2	□ Preferred-Care Option 2
□ Preferred-Care Blue 3	□ BlueSelect Plus Option 3	□ Preferred-Care Option 3
□ Preferred-Care Blue BlueValue Option 1	□ BlueSelect Plus BlueValue Option 1	□ Preferred-Care BlueValue Option 1
□ Preferred-Care Blue BlueValue Option 2	□ BlueSelect Plus BlueValue Option 2	□ Preferred-Care BlueValue Option 2
□ PersonalBlue (Personal Care Account + PPO)	□ BlueSelect Plus PersonalBlue (Personal Care Account + PPO)	□ BlueSelect Plus PersonalBlue (Personal Care Account + PPO)
□ Preferred-Care Blue BlueSaver ‡ (High deductible health plan (HDHP) for use with an HSA)	□ BlueSelect Plus BlueSaver ‡ (High deductible health plan (HDHP) for use with an HSA)	□ Preferred-Care 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?	*‡ Would you like to set up an HSA with your Employer's preferred bank?*	*‡ Would you like to set up an HSA with your Employer's preferred bank?*
□ *YES* □ *NO*	□ *YES* □ *NO*	□ *YES* □ *NO*
(if Yes, please complete section VII)	*(if Yes, please complete section VII)*	*(if Yes, please complete section VII)*

Blue-Care HMO

□ Blue-Care Option 1 □ RateSaver Option 1
□ Blue-Care Option 2 □ RateSaver Option 2

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)

V Ancillary Coverage Selection

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

□ Preferred-Care □ BluePremier □ Traditional

Dental 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)

LAST NAME _____ **FIRST NAME** _____

VI Other Health Insurance Carrier (for Coordination of Benefits)

1. On the day the coverage begins, will you or any of your dependents applying for this coverage 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

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 If You Are Enrolling in a BlueSaver product 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. AN HSA WILL* **NOT** *BE OPENED IF ONLY A POST OFFICE BOX IS PROVIDED.)*

LAST NAME _____ **FIRST NAME** _____

IX Agreement and Acknowledgement

I request coverage under the Group Contract(s) ("Contract") issued by Blue Cross and Blue Shield of Kansas City and Good Health HMO, Inc. d/b/a Blue Care Inc. (collectively, "Blue KC") 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 will be available subject to the exclusions, limitations and benefits described in, as applicable, the Contract. 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 that a person listed on this application did not meet the Contract's or Policy's definition of dependent, Blue KC 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 has 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 in accordance with applicable federal and state laws.

If electing the BlueSaver Plan, I acknowledge that this High Deductible Health Plan ("HDHP") is for use with a Health Savings Account ("HSA").

If I have elected the BlueSaver Plan and applied to open an HSA with UMB Bank, n.a. ("UMB"), I acknowledge that the HSA that I have applied for will be governed by the terms and conditions, including the fees, disclosed in the documents that will be mailed to me within ten (10) days after my HSA has been opened. I request that UMB mail me an HSA debit card so that I can use it to access funds in my HSA, and I acknowledge that my use of the debit card will be governed by the Cardholder Agreement that will be sent with the Card.

I authorize Blue KC as the insurer of my HDHP, UMB, and my Employer and/or their third party service providers, to exchange information about my identity, enrollment elections and status and other information necessary to establish my HSA at UMB, to facilitate direct deposits to my HSA, and to accomplish other purposes related to payment for my healthcare expenses. I agree to indemnify and hold harmless my Employer, UMB, Blue KC, and their third party service providers against all claims or losses that any of them may suffer in reliance on this authorization, and release each of them from any claims or liability based on this authorization.

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 health plan's coverage does not include an elective pregnancy termination benefit.