BlueCross BlueShield of Kansas City

An Independent Licensee of the Blue Cross and Blue Shield Association

Employee Application & Change Form

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

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

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 ☐ Married ☐ M ☐ Single ☐ 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 / Change		EMPLOYEE		☐ Medical ☐ Dental	☐ M ☐ F	**PCP Name:** **PCP No:**	☐ Yes ☐ No
New / Change		SPOUSE		☐ Medical ☐ Dental	☐ M ☐ F	**PCP Name:** **PCP No:**	☐ Yes ☐ No
New / Change		CHILD		☐ Medical ☐ Dental	☐ M ☐ F	**PCP Name:** **PCP No:**	☐ Yes ☐ No
New / Change		CHILD		☐ Medical ☐ Dental	☐ M ☐ F	**PCP Name:** **PCP No:**	☐ Yes ☐ No
New / Change		CHILD		☐ Medical ☐ Dental	☐ M ☐ F	**PCP Name:** **PCP No:**	☐ Yes ☐ 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)
For those electing BlueSaver High Deductible PPO Plan: Do you represent that you are purchasing the high deductible health plan (HDHP) coverage for use with an HSA? ☐ Yes ☐ No*
*If you are covered under a Kansas contract or are a Kansas resident, you must answer 'yes' to this question or you will not be eligible for this BlueSaver coverage option.

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 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, 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: ☐Medical Insurance ☐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 – 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.

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.