



Direct Enrollment

All Questions Must be Answered. Please Print.

(black or blue ink)

Website: www.bcbskc.com

<p>Preferred-Care Blue PPO Blue-Care HMO</p> <p>REQUESTED EFFECTIVE DATE: _____/1/_____ <small>(HIPAA eligible individuals may request an effective date other than the first of a month)</small></p>	<p><input type="checkbox"/> New Application</p> <p><input type="checkbox"/> Change (If application is to be used as a Change Form, please specify event below): <input type="checkbox"/> Birth <input type="checkbox"/> Death <input type="checkbox"/> Marriage <input type="checkbox"/> Divorce <input type="checkbox"/> Address <input type="checkbox"/> Placement/Adoption <input type="checkbox"/> Change in Benefits (health questions must be answered if increasing benefits and/or decreasing deductible)</p> <p>Date of Event: _____</p>	<p>List Bill Number</p>
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I – Applicant Information

1. Last Name	First Name	M.I.	2. Date of Birth	3. Social Security No.
4. *Home Address (Street Number and Name, Apt. Number)			City and State	County Zip Code
5. *Alternate Address (Please indicate only one): <input type="checkbox"/> Billing Only <input type="checkbox"/> Billing and All Correspondence			City and State	County Zip Code
6. Marital Status/ Sex <input type="checkbox"/> Married <input type="checkbox"/> M <input type="checkbox"/> Single <input type="checkbox"/> F	7. Daytime Phone No. ()	8. Applicant's Employer		9. Spouse's Employer
10. Home Phone No. ()		11. E-mail Address:		BCBSKC may use this email address for: <input type="checkbox"/> application notifications

II – Coverage Selection

TYPE OF COVERAGE DESIRED (check only one)	CHECK THE BENEFIT OPTION DESIRED (check only one)		
<input type="checkbox"/> Individual <input type="checkbox"/> Family <input type="checkbox"/> Contractholder/Spouse <input type="checkbox"/> Contractholder/Child(ren)	Preferred-Care Blue PPO: Premium/Child <input type="checkbox"/> \$500 Deductible <input type="checkbox"/> \$1,000 Deductible <input type="checkbox"/> \$2,500 Deductible <input type="checkbox"/> \$5,000 Deductible	Preferred-Care Blue PPO: Rate Saver <input type="checkbox"/> \$500 Deductible <input type="checkbox"/> \$1,000 Deductible <input type="checkbox"/> \$2,500 Deductible <input type="checkbox"/> \$5,000 Deductible <input type="checkbox"/> \$10,000 Deductible	Preferred-Care Blue PPO: BlueSaver (High Deductible Plan for use with an HSA) ‡ <input type="checkbox"/> \$1,500 Deductible <input type="checkbox"/> \$2,500 Deductible <input type="checkbox"/> \$5,000 Deductible

For those electing a Preferred Care Blue BlueSaver plan for use with an HSA:

Do you represent that you are purchasing the BlueSaver plan coverage for use with a Health Savings Account (HSA)? Yes No*

*Kansas applicants must answer 'yes' to this question or they will not be eligible for this HSA/BlueSaver coverage option.

III – Applicant/Family Information – List all individuals desiring coverage: (if additional space needed, please use another application form)

SOCIAL SECURITY NO.	Last Name	First Name	MI.	Date of Birth	Exact Height	Exact Weight	Sex	PCP Name - <i>Complete only for HMO</i>	Current Patient
APPLICANT				/ /			<input type="checkbox"/> M <input type="checkbox"/> F	PCP Name: PCP No:	<input type="checkbox"/> Yes <input type="checkbox"/> No
SPOUSE				/ /			<input type="checkbox"/> M <input type="checkbox"/> F	PCP Name: PCP No:	<input type="checkbox"/> Yes <input type="checkbox"/> No
DEPENDENT				/ /			<input type="checkbox"/> M <input type="checkbox"/> F	PCP Name: PCP No:	<input type="checkbox"/> Yes <input type="checkbox"/> No
DEPENDENT				/ /			<input type="checkbox"/> M <input type="checkbox"/> F	PCP Name: PCP No:	<input type="checkbox"/> Yes <input type="checkbox"/> No

*Home address denotes applicant's permanent legal address and must be completed. Alternate address should be selected if billing, I.D. cards, etc. should go to a different address than the applicant's home address.

Last Name:

First Name:

Social Security Number

IV(a) – Health Statements – ALL QUESTIONS MUST BE ANSWERED BEFORE APPLICATION IS PROCESSED

Please check (✓) the “Yes” box if you or any person applying for coverage ever received, in the past five years, medical services from a health care provider for any of the conditions listed below. If “Yes” box is checked, please explain completely and in detail in the space provided on next page.

<p>1. <input type="checkbox"/> Yes <input type="checkbox"/> No Any arthritis (specify type), fibromyalgia, lupus, connective tissue disease, gout, osteoporosis, degenerative joint or disc disease, spina bifida, polio, or temporal mandibular joint (TMJ) disorder. Any disease or injury, including fractures, dislocations, and bone disorders secured with/without pins or screws. Any disease or injury to joint(s) including back, neck, and spine, such as diminished range of motion in the joints (if yes, please indicate the joint(s) affected). Any loss of limb. Any disorder or injury to tendons, including diminished range of motion.</p>	<p>14. <input type="checkbox"/> Yes <input type="checkbox"/> No Any disorder of the brain, nervous system, including chronic fatigue syndrome, epilepsy, seizures, convulsions, fainting spells, Lyme disease, meningitis, multiple sclerosis, muscular dystrophy, cerebral palsy, sleep disorders, paralysis, Alzheimer’s, Parkinson’s disease, stroke, TIA’s (Transient Ischemic Attacks), migraine or recurrent headaches. If yes to seizures or convulsions, provide date of last episode _____.</p>
<p>2. <input type="checkbox"/> Yes <input type="checkbox"/> No Chest pain, shortness of breath, heart murmur, irregular heartbeat, heart attack, congestive heart failure, rheumatic fever, heart valve disorder, aneurysm, high cholesterol, or high blood pressure or any other heart disorder. If yes to high cholesterol or blood pressure, please provide readings and date even if no treatment was recommended. a) Cholesterol reading: _____ Date: _____ b) Blood pressure reading: ____/____ Date: _____</p>	<p>15. <input type="checkbox"/> Yes <input type="checkbox"/> No a) Disorder of the male or female reproductive organs including enlarged prostate, prostatitis, menstrual irregularities or disorder, endometriosis, fibroid uterus (benign tumor or mass in or on the uterus), abnormal pap smear, ovarian cyst, polycystic ovaries or sexually transmitted disease. Infertility or impotency. (If abnormal pap smears, please provide a copy of your last pap smear result.) b) Breast disorders, fibrocystic disease, breast implant (saline or silicone) please specify.</p>
<p>3. <input type="checkbox"/> Yes <input type="checkbox"/> No Anemia, leukemia, hemophilia, varicose veins, clots, phlebitis, poor circulation or any other vein, artery or blood disease or disorder.</p>	<p>16. <input type="checkbox"/> Yes <input type="checkbox"/> No Nephritis, kidney stones, kidney reflux, bladder infections, kidney infections, blood in urine or any other disease or disorder of the bladder, kidneys or urinary system.</p>
<p>4. <input type="checkbox"/> Yes <input type="checkbox"/> No HIV infection, AIDS, AIDS Related Complex (ARC) or tested positive for HIV or other diseases related to the immune system other than HIV.</p>	<p>17. <input type="checkbox"/> Yes <input type="checkbox"/> No Any type of cancer, tumors, cysts, polyps, or other growth. If yes, please provide the location _____.</p>
<p>5. <input type="checkbox"/> Yes <input type="checkbox"/> No Any disease or disorder of the esophagus, stomach, intestines, bowels, rectum, gallbladder, pancreas or spleen; including reflux, heartburn, gastritis, diverticulitis, diverticulosis, hernia, colitis, hemorrhoids, ulcerative colitis, Crohn’s disease or liver disorder including cirrhosis or Hepatitis A, B or C.</p>	<p>18. <input type="checkbox"/> Yes <input type="checkbox"/> No Crossed eyes, detached retina, retinopathy, cataract, glaucoma or any other eye injury or disorder. If glaucoma, give most recent eye pressure readings for each affected eye. Left Eye Reading: ____ Date: ____ Right Eye Reading: ____ Date: ____</p>
<p>6. <input type="checkbox"/> Yes <input type="checkbox"/> No Ear infections, Meniere’s disease, hearing impairment, deviated nasal septum, sinusitis, sinus problems or any other disorder of the ear, nose or throat.</p>	<p>19. <input type="checkbox"/> Yes <input type="checkbox"/> No Allergies (including allergy shots), hay fever, asthma, emphysema, pleurisy, tuberculosis, chronic bronchitis, chronic cough, chronic obstructive pulmonary disease, or any other disease or disorder of the lungs or respiratory system.</p>
<p>7. <input type="checkbox"/> Yes <input type="checkbox"/> No Diabetes, hypoglycemia, thyroid disorder, goiter, pituitary disorder or any other disorder of the glands. If answer is yes to diabetes, please answer the following: Date of Diagnosis: _____ Controlled by: Diet ___ Oral Medication ___ Insulin _____(units per day). Please provide the most current hemoglobin A1C reading completed within the past 6 months. Reading: _____ Date: _____</p>	<p>20. <input type="checkbox"/> Yes <input type="checkbox"/> No Nervous, mental or emotional conditions, attempted suicide, depression or any of the following disorders: bipolar/manic, anxiety, schizophrenia, attention deficit disorder, anorexia or bulimia, mental retardation. Individual, marital or family counseling. If any counseling received, provide date of last visit _____. If yes, frequency of visits, (circle one) weekly, monthly, other (explain _____).</p>
<p>8. <input type="checkbox"/> Yes <input type="checkbox"/> No Cystic acne, actinic keratosis, psoriasis, eczema, severe burn, severe scars or any other skin disorder.</p>	<p>21. <input type="checkbox"/> Yes <input type="checkbox"/> No Any other abnormality, deformity or congenital birth defect not listed which you or any person applying for coverage now have or have received treatment for in the last 5 years?</p>

Please check (✓) appropriate box to answer the following questions. If “Yes” box is checked, please explain completely and in detail in the space provided in sections IV (b) and (c).

<p>9. <input type="checkbox"/> Yes <input type="checkbox"/> No Are you or any family member or dependent currently pregnant? (Including any dependent <u>not</u> applying for coverage?) If yes, Name: _____ Due Date: _____ Relationship to Applicant: _____</p>	<p>22. <input type="checkbox"/> Yes <input type="checkbox"/> No Have you or any person applying for coverage ever smoked or used tobacco products, including cigarettes, cigars, pipes, or chewing tobacco in the last 5 years? If “yes”, for how long? _____ How much used daily? _____ If no longer using tobacco products, when did you quit? _____</p>
<p>10. <input type="checkbox"/> Yes <input type="checkbox"/> No Have you or any person applying for coverage ever had or been advised to have a transplant of any type in the last 5 years?</p>	<p>23. <input type="checkbox"/> Yes <input type="checkbox"/> No Have you or any person applying for coverage taken medication, or been advised to take medication, within the last year? If yes, list all medications in Section IV(c).</p>

Member Information (Please provide again to assist in case pages become separated.)

Last Name: _____ First Name: _____ Social Security Number _____

IV(a) – Health Statements (Continued) (If you need more space, please attach an additional page)

<p>11. <input type="checkbox"/> Yes <input type="checkbox"/> No Have you or any person applying for coverage 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; b) If yes to any items in (a) please indicate types of treatment and dates. Date and Type of Treatment: _____ c) Been convicted of a DUI in the last 5 years? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>24. <input type="checkbox"/> Yes <input type="checkbox"/> No Have you or any person applying for coverage 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 or been hospitalized in the last 5 years.</p>
<p>12. <input type="checkbox"/> Yes <input type="checkbox"/> No In the last 5 years, have you or any person applying for coverage used illegal hallucinogens, illegal substances, illegal narcotics or any other illegal drugs? If yes, please indicate type of drug and date last used. _____</p>	<p>25. Please provide date of last physical examination _____.</p>
<p>13. <input type="checkbox"/> Yes <input type="checkbox"/> No Within the last 12 months have you or any person applying for coverage been advised to have surgery, treatment, tests or studies that have NOT YET BEEN PERFORMED?</p>	

IV(b) – Professional Services (Give COMPLETE details in all sections below of any “Yes” answers to the questions in Section IV(a).)

Question #	Name of Family Member (As identified on Physician’s Record)	Name of Hospital, Clinic and/or Person Providing Care	Phone No. ()
Date of Onset/Treatment (Month/Year)	Date Ended	<input type="checkbox"/> Still Under Treatment	Suite No.
Name of Condition/Illness		City / State/ ZIP Code	Fax No. ()
Treatment Rendered (i.e., x-ray, lab, surgical procedure, etc.) / Results			

Question #	Name of Family Member (As identified on Physician’s Record)	Name of Hospital, Clinic and/or Person Providing Care	Phone No. ()
Date of Onset/Treatment (Month/Year)	Date Ended	<input type="checkbox"/> Still Under Treatment	Suite No.
Name of Condition/Illness		City / State/ ZIP Code	Fax No. ()
Treatment Rendered (i.e., x-ray, lab, surgical procedure, etc.) / Results			

Question #	Name of Family Member (As identified on Physician’s Record)	Name of Hospital, Clinic and/or Person Providing Care	Phone No. ()
Date of Onset/Treatment (Month/Year)	Date Ended	<input type="checkbox"/> Still Under Treatment	Suite No.
Name of Condition/Illness		City / State/ ZIP Code	Fax No. ()
Treatment Rendered (i.e., x-ray, lab, surgical procedure, etc.) / Results			

IV(c) Prescription Medications – List ALL medications taken within the last 12 months by any family member listed on this application

Family Member	Medication/Dosage/Frequency (i.e., Lopressor/100mg/daily)	Illness for which Medication is Prescribed	Date Prescribed (Mo/Day/Yr)	Date Discontinued (Mo/Day/Yr)	Name and Phone No. of Physician or Hospital
					Name: _____ Phone: _____
					Name: _____ Phone: _____

Member Information (Please provide again to assist in case pages become separated.)

Last Name: _____ First Name: _____ Social Security Number: _____

IV(c) Prescription Medications – List ALL medications taken within the last 12 months by any family member listed on this application

Family Member	Medication/Dosage/Frequency (i.e., Lopressor/100mg/daily)	Illness for which Medication is Prescribed	Date Prescribed (Mo/Day/Yr)	Date Discontinued (Mo/Day/Yr)	Name and Phone No. of Physician or Hospital
					Name: _____ Phone: _____
					Name: _____ Phone: _____

V – General Information

Name, address and telephone number of family physician(s).

- YES NO If Applicant is rejected for coverage, is coverage still desired for spouse and/or dependents? _____
- YES NO Do you now have or have you ever had coverage with Blue Cross and Blue Shield of Kansas City? If yes, approximate dates of coverage _____
- YES NO Does your spouse/dependents now have or have they ever had coverage with Blue Cross and Blue Shield of Kansas City? If yes, approximate date of coverage _____

Applicant:	Certificate/Identification No: _____
Spouse:	Certificate/Identification No: _____
Dependents:	Certificate/Identification No: _____

VI – Creditable Coverage (All applicant’s MUST COMPLETE this section for accurate processing of application)

To be considered a HIPAA eligible individual eligible for guarantee issue coverage* and/or not be subject to the pre-existing condition exclusion; you must have at least 18 months of creditable coverage without a 63-day break in coverage; your most recent health coverage must have been under a group health plan; you cannot currently be eligible for Medicare or Medicaid or be covered under any other health insurance; your most recent coverage cannot have been terminated due to fraud or non-payment of premiums; and if you were eligible for continuation coverage under COBRA or a similar state program, you elected such continuation coverage and you have fully exhausted that coverage available.

* Guarantee issue coverage is available to Missouri Residents - only.

Failure to answer the questions under this Section VI accurately may result in the loss of your rights as an eligible individual including the right to a guarantee issue policy and waiver of the pre-existing condition exclusion in our PPO Plans.

- YES NO Have you or any person applying for coverage had a minimum of 18 months of continuous health coverage most recently under a group health plan that is still active or that ended within the last 63 days for a reason other than fraud or non-payment of premium? **If yes, please list names:** _____, _____, _____
IF ‘YES’, PLEASE PROVIDE CERTIFICATE(S) OF CREDITABLE COVERAGE OR OTHER ACCEPTABLE PROOF OF COVERAGE, FROM THE PRIOR PLAN(S).
(Note, you may find information on other acceptable proof in your Direct Pay Brochure.)
- YES NO Did you or any person applying for coverage elect COBRA or state continuation? **If no, please explain.**
- YES NO If COBRA or state continuation was elected, have you or any person applying for coverage exhausted COBRA or state continuation coverage?
- YES NO Do you or any person applying for coverage have other health insurance coverage, or are eligible for any group health plan, Medicare or Medicaid?
If Yes, please list names and explain: _____

Name	Medicare/Medicaid Policy Number	Effective Date	Medicare			
			Part A		Part B	
		/ /	Yes	No	Yes	No
		/ /	Yes	No	Yes	No
		/ /	Yes	No	Yes	No

Add additional names and information on separate piece of paper.

Member Information (Please provide again to assist in case pages become separated.)

Last Name: First Name: Social Security Number

5. If you or any person applying for PPO coverage qualify as a HIPAA eligible individual then such individual is not subject to any pre-existing condition exclusion. However, a surcharge of approximately 10% of the underwritten premium will be added to your premium. You may elect to have the pre-existing condition exclusion apply on our PPO plans and no surcharge will be applied to the underwritten premium.

YES* NO Do you wish to have your pre-existing conditions covered on the PPO plan you elected in Section II for an additional surcharge? If so, we will notify you of the premium rate for this coverage.

*If you mark "no", pre-existing conditions will not be covered under the PPO plan for 12 consecutive months beginning on your effective date of coverage.

6. YES NO For Missouri residents only who qualify as a HIPAA eligible individual-If you or any one applying for coverage does not qualify for our underwritten health plans due to health conditions, would you or such person like to apply for one of our guarantee issue plans? Please note, the rates may be significantly higher than our underwritten plan.

Please select the guarantee issue policy being applied for: Preferred-Care Blue PPO Premium \$500 Deductible ___ Preferred-Care Blue PPO Rate Saver \$1,000 Deductible ___

Rates will be provided if you do not qualify for our underwritten plans.

VII- Agreement

I request coverage under the Direct Enrollment Contract ("Contract") issued by Blue Cross and Blue Shield of Kansas City ("BCBSKC") or its subsidiary, Good Health HMO, Inc. I understand services will be available subject to the exclusions, limitations, and benefits described in the Contract(s). I understand that even though I may have disclosed the names of my health providers or my dependents' health providers on this application, BCBSKC may not have obtained medical records from such providers. I understand that BCBSKC relies on the truth of my answers and statements and that the Contract is conditioned upon the truth contained herein. I acknowledge that if I or any dependent is employed, such employer is not contributing toward the cost of this coverage. I understand that any misstatement on this enrollment application may result in a denial of a claim, re-rate of the premium, discontinuation or rescission of coverage. I understand that if at any time it is determined by BCBSKC that a person listed on this application did not meet the Policy's definition of dependent, or I misrepresented any of the information contained herein; BCBSKC and/or its subsidiaries have the right to re-rate, terminate or rescind coverage for that person or for all persons under the application, and to recover any benefit payments for such person or persons. I understand that no statement I make will void 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 my medical records will be maintained with strict confidentiality by BCBSKC in accordance with applicable federal and state laws.

(PARENT OR GUARDIAN SIGNATURE REQUIRED FOR MINORS UNDER THE AGE OF 18.)

Applicant's Signature:

Spouse's Signature:

Printed Name:

Printed Name:

Date:

Date:

VIII- Broker Representation (if applicable)

I represent that to the best of my knowledge all statements are complete and accurate.

BCBS Broker No.

PRINTED BROKER'S NAME

BROKER SIGNATURE

DATE

REQUIRED

TELEPHONE NO.

E-MAIL ADDRESS

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.

PLEASE RETAIN A COPY OF THIS APPLICATION FOR YOUR RECORDS

How would you like to eliminate the hassle of writing a check each month for your health care premium?

- With Tech-No-Check electronic funds transfer, your monthly premium is automatically deducted from your checking account.
- Your premium will be paid automatically, on time, each and every month.
- Your account will be drafted on the 5th of each month or next business day.
- You will be notified when Tech-No-Check is in force. (Pay as billed until you are notified that Tech-No-Check is activated. Depending on the timeliness of Your application, there may be a delay in drafting the first month's premium. Should this occur, You will receive a paper bill for the first month's premium. You may pay Your bill online at BCBSKC.com.)

Just complete the section below and sign.

NOTE: To cancel your electronic funds transfer authorization, your request must be received 10 days prior to your electronic funds transfer withdrawal date.

NAME:	SOCIAL SECURITY NO:
NAME OF BANK	NAME ON ACCOUNT
ROUTING NUMBER (8 digit #)	BANK ACCOUNT #
Yes, I want Tech-No-Check.	
SIGNATURE:	DATE:

CREDIT CARD AUTHORIZATION: We offer the convenience of paying by credit card. Payment by credit card can be accepted for a payment of one or more premiums; or with your signed authorization, we can automatically charge your credit card for your full premium each month. To pay by credit card, select on of the following options (*all information must be complete for processing*):

- Please charge my credit card for one premium payment in the amount of \$.
- Please charge my credit card automatically each month for the full premium amount due. I understand that my credit card will be charged each month on the _____ day of the month.

Choose only one: Visa Master Card American Express Discover

Account Number: _____ Expiration Date: _____

Account Name: _____ Signature: _____

NOTE: To cancel your automatic credit card authorization, your request must be received 10 days prior to your credit card withdrawal date.

OFFICE USE ONLY					
DATE RECEIVED	GROUP	STATUS A P R D	PREMIUM	APPLICANT	
UNDERWRITER	SUBGROUP	POLICY TYPE N C R	PRE-X EFFECTIVE DATE	DEP. 1	
RESTART DATE	CLASS	RISK	CONDITIONAL ELIGIBILITY EFFECTIVE DATE	DEP. 2	
2 ND RESTART DATE	H PLAN	AREA/ISSUE AGE	CONDITIONAL ELIGIBILITY TERM DATE	DEP. 3	
RELEASE DATE	D PLAN	EFFECTIVE DATE	SUBSCRIBER ID	DEP. 4	
REASON FOR RISK:				DEP. 5	
				DEP. 6	
				PRE-X EFFECTIVE DATE FOR DEPENDENT(S)	