Enrollment Form

with health statement – for First Choice coverage

BlueCross BlueShield Kansas

I understand that completing this form in **no way obligates me to purchase coverage**. I will complete the information below for each person requesting coverage. I understand all information is kept confidential.

Please answer all of the following questions for each person interested in coverage.

Section 1 – Applicant Information

Clear data

First Name _____ MI _____

Last Name _____ Suffix _____

Residential Address _____

City _____

State _____ ZIP Code _____ +4 _____ County _____

Mailing Address (if different from residential address) _____

City _____

State _____ ZIP Code _____ +4 _____

Gender ☐ Male ☐ Female

Social Security Number _____-_____-_____

Home Phone Number (_____) _____-_____

Work Phone Number (_____) _____-_____

Email Address _____

Married? ☐ Yes ☐ No
If yes, give date of marriage.

Date of Birth _____ /_____ /_____

Height _____ Weight _____

Cell Phone Number (_____) _____-_____

Fax Number (_____) _____-_____

Date of Marriage _____ /_____ /_____

Section 2 – Blue Cross Membership Information

I currently have Blue Cross coverage. ☐ Yes ☐ No

Member ID Number _____

I am replacing my current Blue Cross coverage with this policy. ☐ Yes ☐ No

I want to add a family member to my existing policy. ☐ Yes ☐ No

Type of coverage I am choosing: (check all that apply)

☐ Health ☐ Dental

I want coverage for: (Check one)

☐ Myself only* ☐ Myself and my spouse

☐ Myself and my child(ren) ☐ Myself and my family

* Must be at least 19 years of age

Section 3 – Spouse and Dependent Information

Dependents must be under age 26 and a dependent either naturally, through adoption, as a stepchild or you must have legal guardianship or legal custody.

Relationship to applicant: ☐ Spouse ☐ Child ☐ Stepchild ☐ Legal Guardianship ☐ Legal Custody

First Name _____ MI _____

Last Name _____ Suffix _____

Gender ☐ Male ☐ Female

Social Security Number _____-_____-_____

Date of Birth _____ /_____ /_____

Height _____ Weight _____

For office use only

Sys. Number | Rep. Number | Date

Business Name

Please continue on the next page.

Section 3 – Spouse and Dependent Information (continued)

Relationship to applicant: ☐ Spouse ☐ Child ☐ Stepchild ☐ Legal Guardianship ☐ Legal Custody

First Name ____ MI ____ Gender ☐ Male ☐ Female ____/____/____ Date of Birth

Last Name ____ Suffix ____ Social Security Number ____-____-____ Height ____ Weight ____

Relationship to applicant: ☐ Spouse ☐ Child ☐ Stepchild ☐ Legal Guardianship ☐ Legal Custody

First Name ____ MI ____ Gender ☐ Male ☐ Female ____/____/____ Date of Birth

Last Name ____ Suffix ____ Social Security Number ____-____-____ Height ____ Weight ____

Relationship to applicant: ☐ Spouse ☐ Child ☐ Stepchild ☐ Legal Guardianship ☐ Legal Custody

First Name ____ MI ____ Gender ☐ Male ☐ Female ____/____/____ Date of Birth

Last Name ____ Suffix ____ Social Security Number ____-____-____ Height ____ Weight ____

Relationship to applicant: ☐ Spouse ☐ Child ☐ Stepchild ☐ Legal Guardianship ☐ Legal Custody

First Name ____ MI ____ Gender ☐ Male ☐ Female ____/____/____ Date of Birth

Last Name ____ Suffix ____ Social Security Number ____-____-____ Height ____ Weight ____

Relationship to applicant: ☐ Spouse ☐ Child ☐ Stepchild ☐ Legal Guardianship ☐ Legal Custody

First Name ____ MI ____ Gender ☐ Male ☐ Female ____/____/____ Date of Birth

Last Name ____ Suffix ____ Social Security Number ____-____-____ Height ____ Weight ____

Relationship to applicant: ☐ Spouse ☐ Child ☐ Stepchild ☐ Legal Guardianship ☐ Legal Custody

First Name ____ MI ____ Gender ☐ Male ☐ Female ____/____/____ Date of Birth

Last Name ____ Suffix ____ Social Security Number ____-____-____ Height ____ Weight ____

Relationship to applicant: ☐ Spouse ☐ Child ☐ Stepchild ☐ Legal Guardianship ☐ Legal Custody

First Name ____ MI ____ Gender ☐ Male ☐ Female ____/____/____ Date of Birth

Last Name ____ Suffix ____ Social Security Number ____-____-____ Height ____ Weight ____

Has anyone listed in this section gained entry to the U.S. through a VISA? ☐ Yes ☐ No

____

If yes, who and what type?

Please continue on the next page.

Section 4 – Health Statement Questionnaire

This section asks questions about health conditions. Don't be overly concerned about answering "yes" to a question. A "yes" doesn't automatically disqualify you from coverage. Remember to mark "yes" only if medical service for the listed condition has been received in the last 5 years, then give details in the next section. Please check the boxes "yes" or "no". For each answer marked "yes", circle the condition and explain in the next section. The questions answered for individuals under age 19 will only be used for rating purposes.

Yes No

☐ ☐ 1. Do you or any dependent currently smoke?

_____
If yes, list those who currently smoke

2. Have you or any other person(s) to be insured been diagnosed or treated for any of the following in the past 5 years:

☐ ☐ a. heart or circulatory problems?

☐ ☐ b. high blood pressure?

_____ /_____
If yes, provide average of last 3 readings

☐ ☐ c. lung or respiratory problems?

☐ ☐ d. disorder of kidneys or reproductive organs?

☐ ☐ e. disorder of liver, gallbladder, intestines, rectum, stomach or other vital organs?

☐ ☐ f. diabetes or high blood sugar?

_____
If yes, provide A1C reading

☐ ☐ g. neurological disorder, stroke, physical incapacitation, seizures?

_____ /_____ /_____
If yes, provide date of last seizure

☐ ☐ h. immune deficiency disorder or AIDS/AIDS-related complex?

☐ ☐ i. cancer or malignancy?

☐ ☐ j. blood, gland or skin problems?

☐ ☐ k. arthritis, paralysis, disease or disorder of the muscles, bones or joints?

☐ ☐ l. disorder of the esophagus, throat, nose or eyes (not including eye glasses or contact lenses)?

☐ ☐ m. alcoholism or other drug/substance dependency?

☐ ☐ n. depression, anxiety or any mental/nervous condition?

3. In the past five years, have you or any other person(s) to be insured:

☐ ☐ a. consulted a health care provider, received treatment at a hospital or other medical facility or been advised to have treatment for any other condition not listed?

☐ ☐ b. used any narcotics or controlled substances, except as legally prescribed by a physician?

☐ ☐ c. taken a prescription drug for a continuous 30-day or more period? (indicate treatment dates in the next section)

☐ ☐ 4. Are you or any of the persons listed pregnant?

☐ ☐ 5. Are you or any dependent disabled or aware of any condition that has prevented you or any dependent from receiving health, life or accident insurance in the past 5 years?

Please continue on the next page.

Section 5 – Health Statement Questionnaire Follow-up

Explain conditions in detail for any "yes" responses in the previous section. Omitted information may cause delays. If additional space is needed, please attach a separate sheet.

Question No. ______ Person Treated ______ Date Diagnosed/Treated ___/___/___ Date Physician Last Seen ___/___/___

Diagnosis or details about condition, treatment, medication name and dosage:

Is further treatment recommended? ☐ Yes ☐ No
If yes, explain:

Physician Name

City State

Question No. ______ Person Treated ______ Date Diagnosed/Treated ___/___/___ Date Physician Last Seen ___/___/___

Diagnosis or details about condition, treatment, medication name and dosage:

Is further treatment recommended? ☐ Yes ☐ No
If yes, explain:

Physician Name

City State

Question No. ______ Person Treated ______ Date Diagnosed/Treated ___/___/___ Date Physician Last Seen ___/___/___

Diagnosis or details about condition, treatment, medication name and dosage:

Is further treatment recommended? ☐ Yes ☐ No
If yes, explain:

Physician Name

City State

Question No. ______ Person Treated ______ Date Diagnosed/Treated ___/___/___ Date Physician Last Seen ___/___/___

Diagnosis or details about condition, treatment, medication name and dosage:

Is further treatment recommended? ☐ Yes ☐ No
If yes, explain:

Physician Name

City State

Please continue on the next page.

Section 6 – Health Statement Important Information

Waiting Periods: You (and all family members) will have a 240-day waiting period from the effective date of coverage on the following conditions (whether or not the condition existed prior to the effective date of the policy):

1. Obstetrical services[1] — standard plan includes coverage on Individual/Spouse and Individual/Spouse/Children policies.
2. Operations for removal of tonsils and/or adenoids.
3. Treatment for tumors or growths.
4. Treatment for hernia.
5. Treatment for conditions of gallbladder, rectum and genito-urinary tract.

[1] Obstetrical services on Individual and Individual/Children policies are available upon request at an additional premium. If purchased, obstetrical services are subject to the above 240-day waiting period.

When a condition subject to a waiting period is the primary diagnosis, the waiting period applies to all conditions treated during that hospital or medical care facility stay.

The waiting periods do not apply to a newborn child, if the child would otherwise be covered by the parent's coverage.

Single Maternity Coverage: There is no single maternity coverage included in this policy unless you wish to purchase a single maternity rider separately at an additional premium.

Pre-Admission Certification: All admissions to hospitals and medical care facilities for inpatient care require prior authorization by Blue Cross and Blue Shield of Kansas, unless the admission is for a life-threatening condition or for obstetrical care. If no pre-admission request is made, you may be financially responsible for any medically unnecessary services provided.

Please read the following important statements and **sign the authorization statement** to complete your enrollment form.

- I understand that Blue Cross and Blue Shield of Kansas, Inc. (BCBSKS) will re-rate, terminate or rescind the contract for the following conditions: 1) if the information received from future claims or supporting records within two years after the date the contract becomes effective indicates information provided on this enrollment form was incorrect; 2) if such information received at any time indicates the information provided in this enrollment form intentionally misrepresented a material fact or was fraudulent. **Rescinding only pertains to individual/non-group contracts and is not applicable to group contracts.**
- I understand no representative of BCBSKS has the authority to waive any information required on this enrollment form; or to bind BCBSKS to provide coverage for me or any of my dependents or to waive, alter or change the provisions of the contract which may be issued.
- I understand that my signature verifies that I have read all of the information on this form and represent that all statements made herein are complete and true to the best of my knowledge. I understand BCBSKS shall have no liability for payment of services until all of the following occur: 1) the enrollment form has been received and approved, 2) an official contract has been issued and delivered, and 3) the full first premium has actually been paid to and accepted by BCBSKS.
- I understand all coverage is subject to the health of all applicants on this enrollment form remaining unchanged to the effective date of coverage. **If any change in health occurs before the effective date of coverage, I understand I must notify the BCBSKS Underwriting Department at 1-800-432-0216.** (A photographic copy of this authorization shall be as valid as the original.)

Please continue on the next page.

Section 7 – Proxy

I hereby appoint the board of directors ("Board") of Blue Cross and Blue Shield of Kansas, Inc., ("Company") as my proxy to act on my behalf at all annual meetings of the policyholders of the Company. This appointment shall include such persons as the Board may designate by resolution to act on its behalf. This proxy gives the Board, or its designee, full power to vote for me on all matters that may be voted upon at any annual meeting. This proxy, unless revoked, shall remain in effect during my membership in the Company. I may revoke this proxy in writing by advising the Company of such at least ten (10) days prior to any meeting. I may also revoke my proxy by attending and voting in person at any annual meeting.

☐ I accept ☐ I do not accept

Section 8 – Authorization for the Release of Protected Health Information

I understand that by signing this enrollment form, I authorize the disclosure of all health information by any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility, other health care provider, insurance company, or any other organization or person who has provided payment, treatment, or services to me or on my behalf or to any of my dependents covered by this enrollment form or on their behalf, to BCBSKS.

I understand that the information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and will no longer by protected by federal privacy regulations.

This authorization is valid for a period no greater than 2 years. I understand that revocation of this authorization will not affect any action taken in reliance upon this authorization before the written revocation was received.

Your signature required

_____ Applicant

_____ / _____ / _____ Date Signed

_____ Print Name

Send your completed application to:

Blue Cross and Blue Shield of Kansas
P.O. Box 517
Topeka, KS 66601-0517

Fax: 785-290-0716