

## **Application Submission Instructions**

**Please complete the attached application and send to Health Plan One either via fax or mail:**

**Health Plan One  
1000 Bridgeport Ave. 4<sup>th</sup> FL  
Shelton, CT 06484**

**Any questions? Please call Health Plan One at 1-877.567.5267. Thank you!**



BlueCross BlueShield  
of Kansas City

An Independent Licensee of the  
Blue Cross and Blue Shield Association

# Direct Enrollment

All Questions Must be Answered. Please Print.  
(black or blue ink)

Website: [www.BlueKC.com](http://www.BlueKC.com)

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

(Please Check One)

List Bill Number

REQUESTED EFFECTIVE DATE:

/1/

(HIPAA eligible individuals may request an effective date other than the first of a month)

New Application

Change (If application is to be used as a Change Form, please specify event below):  Birth

Death  Marriage  Divorce  Address  Placement/Adoption

Change in Benefits (health questions must be answered if increasing benefits and/or decreasing deductible)

Date of Event: \_\_\_\_\_

## 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:		BlueKC 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)	<b>Preferred-Care Blue PPO: Premium/Child</b> <input type="checkbox"/> \$500 Deductible <input type="checkbox"/> \$1,000 Deductible <input type="checkbox"/> \$2,500 Deductible <input type="checkbox"/> \$5,000 Deductible	<b>Preferred-Care Blue PPO: Rate Saver</b> <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	<b>Preferred-Care Blue PPO: BlueSaver (High Deductible Plan for use with an HSA)</b> <input type="checkbox"/> \$1,500 Deductible <input type="checkbox"/> \$2,500 Deductible <input type="checkbox"/> \$5,000 Deductible	<b>Preferred-Care Blue PPO : AffordaBlue</b> <input type="checkbox"/> \$2,500 deductible <input type="checkbox"/> \$5,000 deductible <input type="checkbox"/> \$10,000 deductible

## 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.<br/>a) Cholesterol reading: _____ Date: _____<br/>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. <b>(If abnormal pap smears, please provide a copy of your last pap smear result.)</b> 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: _____<br/>Controlled by: Diet ___ Oral Medication ___ Insulin ___ (units per day).<br/>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 not applying for coverage?)<br/>If yes, Name: _____ Due Date: _____<br/>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? _____<br/>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 <b>NOT YET BEEN PERFORMED?</b></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	Address	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	Address	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	Address	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 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; and your most recent coverage cannot have been terminated due to fraud or non-payment of premiums.

**Failure to answer the questions under this Section VI accurately may result in the loss of your right to a waiver of the pre-existing condition exclusion in our PPO Plans.**

1.  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.)

2. If you or any person applying for PPO coverage is not subject to the pre-existing condition exclusion, 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.

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

Last Name: First Name: Social Security Number

**VII- Agreement**

I request coverage under the Direct Enrollment Contract ("Contract") issued by Blue Cross and Blue Shield of Kansas City ("BlueKC") 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, BlueKC may not have obtained medical records from such providers. I understand that BlueKC relies on the truth of my answers and statements and that the Contract is conditioned upon both the truth of the information I have provided herein and on all matters disclosed herein remain unchanged until the effective date of the Contract. If any information changes or I become aware of information different from that provided in this application, I agree to provide that additional information promptly to BlueKC. 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 or failure to provide additional information about changes prior to the date on which the Contract is issued, 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 BlueKC 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; BlueKC 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 **BlueKC** in accordance with applicable federal and state laws.

**VIII- Authorization to release information**

I hereby authorize any physician, medical practitioner, hospital, clinic, veterans administration facility, pharmacy or pharmacy-related facility; insurance company, reinsurer or consumer reporting agency to give to Company any information regarding diagnosis, treatment and prognosis with respect to any physical, mental or dental condition or any other information pertaining to employment or other medical insurance for me or any member of my family shown on this enrollment form, including any information for which I or a member of my family requested a self-pay restriction from the provider. I further authorize Company to disclose such information to any third parties utilized to provide services or benefits relating to my insurance contract; or any request for such information which Company is legally required to provide. I understand that this authorization is a condition of my enrollment in a BlueKC health plan or eligibility for benefits, and that by not signing this authorization BlueKC may decline to enroll me or to give me benefits. I understand that I may revoke this authorization, in writing; however, any information already used or relied on by BlueKC will not be affected by my revocation. I agree that, unless revoked by me in writing, this authorization shall remain valid for three years from the date signed and that a photocopy of this authorization will be as valid as the original.

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

<b>Applicant's Signature:</b>	<b>Spouse's Signature:</b>
<b>Printed Name:</b>	<b>Printed Name:</b>
<b>Date:</b>	<b>Date:</b>

**IX- Broker Representation (if applicable)**

I represent that to the best of my knowledge all statements are complete and accurate.			BlueKC Broker No.
HEALTH PLAN ONE			<b>05170</b>
PRINTED BROKER'S NAME	BROKER SIGNATURE	DATE	REQUIRED
877-567-5267	sales@healthplanone.com		
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 5<sup>th</sup> of each month or next business day.
  - Please debit my account for one premium payment in the amount of \$ \_\_\_\_\_
  - Please debit my account automatically each month for the full premium amount due.

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 (9 digit #)	BANK ACCOUNT #
<b>Yes, I want Tech-No-Check.</b>	
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 one 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 5th day of the month or next business day.

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
				DEP. 1
UNDERWRITER	SUBGROUP	POLICY TYPE N   C   R	PRE-X EFFECTIVE DATE	DEP. 2
				DEP. 3
RESTART DATE	CLASS	RISK	CONDITIONAL ELIGIBILITY EFFECTIVE DATE	DEP. 4
				DEP. 5
2 <sup>ND</sup> RESTART DATE	H PLAN	AREA/ISSUE AGE	CONDITIONAL ELIGIBILITY TERM DATE	DEP. 6
RELEASE DATE	D PLAN	EFFECTIVE DATE	SUBSCRIBER ID	PRE-X EFFECTIVE DATE FOR DEPENDENT(S)
<b>REASON FOR RISK:</b>				