# Employee Application

## for Alliance* Medical Coverage

## plus Optional Dental Coverage

## and Life/AD&D and Disability Products

***and Comprehensive**

The Companies are Healthy Alliance® Life Insurance Company (HALIC), its parent, RightCHOICE® Managed Care, Inc. (RIT), and certain affiliates. Blue Cross and Blue Shield of Missouri is the name RIT uses to do business in most of Missouri. RIT and certain affiliates administer benefits underwritten by HALIC. RIT and HALIC are independent licensees of the Blue Cross and Blue Shield Association.

# Application Agreement

*(Please read this before signing application.)*

**Applicant/Subscriber** (the person completing and signing this form) **understands and agrees to all the items listed below, on behalf of himself/herself and as the authorized representative of his/her spouse and other covered dependents.**

### *Requesting Coverage:*

I understand that this Application is for the purpose of enrolling in health, dental and other non-health products, such as life and disability products. The information on this Application, except for health history and health status, will be shared with the non-health affiliates of the Companies for the purpose of underwriting, maintaining enrollment and billing services.

Unless indicated otherwise in Section 2 of this form, I request the group coverage to which I am entitled, or may become entitled, under the provisions of the Certificate issued by the Companies.

I authorize proper deductions, if any, from my earnings as my contribution toward the cost of this coverage and agree that my employer may act as my agent under this coverage. I understand that I cannot transfer my or my covered dependents' right to receive benefit payments.

I certify that the information provided on this form is true and correct and attest to the eligibility of all persons listed.

I understand that the Companies rely upon the information I provide on this Application in issuing my coverage. If I omit any information or provide any false or incomplete information, this can result in the cancellation of my coverage. I agree to repay promptly any benefit payments to which I or my dependents were not entitled.

### *Limitations and Waiting Periods:*

*Medical coverage* – I understand that if I am applying when first eligible and my group's coverage is fully underwritten by the Companies, I will not have an exclusion period for coverage of preexisting medical conditions.

I understand that if my group's coverage is not fully underwritten by the Companies, my employer may exclude coverage of any preexisting medical conditions for up to 12 months, or up to 18 months for late enrollees. However, I can reduce or eliminate this exclusion period based on my prior countable Creditable Coverage.

*Dental coverage* – I understand that waiting periods may apply for certain services, as specified in my benefit materials.

*Life/AD&D and Disability coverage* – I understand that waiting periods may apply for long-term disability and/or short-term disability coverage, as specified in my group's Master Policy underwritten by Healthy Alliance Life Insurance Company.

### *Declining Coverage and Applying at a Later Date:*

**Medical, Dental or Medical/Dental Coverage** – If I decide to apply for coverage or add a dependent later for medical, dental or medical/dental coverage, I understand that I and/or any eligible dependent will be accepted, as follows:

- **As long as I apply or add a dependent within 31 days after one of the following events,** coverage will be effective on the date of that event: 1) the other coverage ended because of lost eligibility; 2) the employer stopped contributing to the cost of the other coverage; or 3) marriage or the birth, adoption or placement for adoption of a child. In addition, the Companies will not apply an exclusion period for coverage of preexisting medical conditions. *If dental coverage is included,* waiting periods may apply for certain services, as specified in my benefit materials
- **However, if I wish to apply or add a dependent because of any other situation, other rules apply.** I and/or any dependents will be considered Late Enrollees. Medical coverage: My/our medical coverage will be effective either on my group's next monthly service date or on the first of the month after all necessary information is received by the Companies, whichever occurs first. An 18-month exclusion period will apply for coverage of any preexisting conditions. However, if medical advice or treatment is not received for a preexisting condition during a continuous 12-month period after coverage begins, then that preexisting condition will be covered after that 12-month period. In any case, I/we can reduce or eliminate this exclusion period based on the length of our prior Creditable Coverage, as long as there was no break in that coverage of more than 63 consecutive days. Dental coverage: Depending on the dental plan offered through my group, my/our dental coverage will be effective as follows: DentaMax – effective on the anniversary date of my group; DentaBlue – effective on my group's next monthly service date or on the first of the month after all necessary information is received by the Companies, whichever occurs first, and waiting periods may apply for certain services.

**Life/AD&D and/or Disability Coverage:** If I decide to apply or add a dependent later for life/AD&D and/or disability coverage, I understand that I must complete a health statement and I and/or my dependent might not be accepted for coverage.

***Definition of Total Disability:*** *A Subscriber or a dependent who had been actively working is considered to have a Total Disability if he or she is not actively working because he or she is unable to perform the material and substantial duties of his or her occupation. A retiree or a dependent who had not been actively working is considered to have a Total Disability if he or she is unable, because of an illness or injury, to perform the usual and ordinary activities of a person of like age. In any of these situations, the disability may be either permanent or temporary.*

# Employee Application for Alliance* Medical Coverage plus Optional Dental Coverage and Life/AD&D and Disability Products

*and Comprehensive *(Note: The Comprehensive Plan is not available for new group sales.)*

*— Please Print —* *– Be Sure to Complete Reverse Side —*

## 1. Employment Information *(Be sure to provide all the information requested below.)*

| Employee's Last Name First Name M.I. | Date of Full-Time Employment ___/___/___ mo day year | Occupation | Marital Status ❑ Married ❑ Divorced ❑ Single ❑ Widowed |
|---|---|---|---|

| Home Address: Street City State ZIP County | Home Telephone ( ) |
|---|---|

| Group Name | Group and Sub-Group No., if known | Home Telephone ( ) |
|---|---|---|

Are you: ❑ a full-time active employee ❑ a retiree ❑ currently off work because of illness or injury
❑ a former full-time employee* ❑ a former covered dependent*

**If you checked this box, give the date you became eligible for continuation of coverage (mo / day / yr):*

## 2. Group Health Coverage Information

*Certain coverages and coverage types may be required or* **may not be available to you.** *If unsure, check with your Group Administrator. If declining any of the coverage(s) available to you, please read "Declining Coverage and Applying at a Later Date" in the Application Agreement.*

| **Medical coverage** ❑ Yes ❑ No<br>If **yes**, please check one coverage type:<br>❑ employee ❑ emp. & spouse<br>❑ emp. & children ❑ family | **Type of medical coverage you are applying for** *(check one)*:<br>❑ Alliance ❑ AlliancePreferred<br>❑ AllianceChoice ❑ Comprehensive | **For OptionBlue Groups** *(check one)*:<br>❑ Base PPO Plan<br>❑ Enriched PPO Plan | **Dental coverage** ❑ Yes ❑ No<br>If **yes**, please check one coverage type:<br>❑ employee ❑ emp. & spouse<br>❑ emp. & children ❑ family |
|---|---|---|---|

Do you have any other coverage with us at this time? ❑ Yes ❑ No If **yes,** give current identification #:______________

## 3. Other Health Coverage

**Does anyone listed in Section 5 (*on reverse*) have other health insurance?** ❑ Yes ❑ No If **yes,** give name: ______________

*If other coverage is Medicare, please complete Section 6, question A, on the reverse side.*

| Check one:<br>❑ Individually purchased<br>❑ Purchased through a group* | Insurance company name, address and phone #: | Check one or both:<br>❑ Medical<br>❑ Dental | Check one:<br>❑ Individual<br>❑ Family |
|---|---|---|---|

*If through a group, give group's name: ______________

## 4. Life and Disability Products

**To apply for coverage, complete all appropriate sections below.** ***Note:*** *AD&D is not available without Basic Life. Dependent Life is not available without Basic Life and AD&D. If any of these coverages are paid for in full by the employer, applicants will be automatically enrolled in that coverage. If you are declining any of the coverage(s) available to you, be sure to read "Declining Coverage and Applying at a Later Date" in the Application Agreement.*

| Job Class | Average hours worked per week ______ | Earnings $ ______ | per ❑ Hour ❑ Week ❑ Month ❑ Year |
|---|---|---|---|

| **Basic Life and AD&D** ❑ Yes ❑ No | **Dependent Life*** ❑ Yes ❑ No **Dependent Life age limits differ from medical coverage age limits.* | **Short-Term Disability (STD)** ❑ Yes ❑ No | **Long-Term Disability (LTD)** ❑ Yes ❑ No |
|---|---|---|---|

**Beneficiary Information** *(for Life and AD&D Benefits)*:

| Primary Beneficiary's Last Name First MI | Relationship to Applicant | Social Security No., if known |
|---|---|---|
| Street Address | City | State ZIP |

| Contingent Beneficiary's Last Name First MI | Relationship to Applicant | Social Security No., if known |
|---|---|---|
| Street Address | City | State ZIP |

**I have completed all information required in Sections 1 through 4 above and Sections 5 and 6 on reverse. I represent that all information provided is true and complete. I agree to the conditions of enrollment as explained on the Application Agreement page with the same date as this page.**

**Signature of Applicant X** ______________ **Date X** ______________

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*(continued on reverse)*

## 5. Applicant and Family Information *(Complete for yourself and eligible family members you want covered on your membership. Attach an additional sheet if necessary.)*

| First Name / M.I. / Last *(if different)* | Social Security Number | Relationship to Applicant | Sex M/F | Birthday Mo/Day/Yr | Height ft / in | Weight |
|---|---|---|---|---|---|---|
| ***Applicant*** | | ***Self*** | | | | |
| Spouse | | ***Spouse*** | | | | |
| | ***Social Security Number is not needed for dependent children.*** | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |

## 6. Health Information *(The information below is used to help determine your group's eligibility or rate for health care coverage.)*

**Please provide the applicable information below for any person listed in Section 5. Attach additional sheet if needed.**

A) **Does anyone listed in Section 5 have Medicare?** ☐ Yes ☐ No If **yes,** give:

Name: ______________ Medicare Claim No.: ______________ Part A/B eff. date(s): ______ / ______

Reason(s) eligible: ☐ Age ☐ Disability ☐ End-stage renal disease

B) **Is anyone listed in Section 5:**

(1) **Totally disabled?*** ☐ Yes ☐ No If **yes,** give name: ______________ Date disability began: ______

*(*Total Disability is defined at the end of the Application Agreement page.)*

Is person receiving Social Security benefits? ☐ Yes ☐ No Describe disability: ______________

(2) **Pregnant?** ☐ Yes ☐ No If **yes,** give name: ______________ Expected delivery date: ______

(3) **A tobacco user within the past 12 months?** ☐ Yes ☐ No If **yes,** give name(s): ______________

C) Within the last 10 years, have you, or any family member listed in Section 5, been diagnosed with, or treated for, any of the following:

- ☐ Allergies
- ☐ Arthritis
  - ☐ Lupus
  - ☐ Osteoarthritis
  - ☐ Rheumatoid
- ☐ Back or Neck Disorder
- ☐ Blood Disorder
- ☐ Cancer/Growth
- ☐ Congenital Disease or Birth Defect
- ☐ Cosmetic Surgery
- ☐ Diabetes/Thyroid/Gland Disorder
- ☐ Digestive/Intestinal Disorder
  - ☐ Crohn's Disease/Ileitis
  - ☐ Irritable Bowel Syndrome
  - ☐ Reflux/Ulcer/Heartburn
  - ☐ Ulcerative Colitis
- ☐ Heart/Circulatory Disorder
  - ☐ Coronary Artery Disease/ Heart Attack
  - ☐ Irregular Heartbeat
  - ☐ Heart Murmur
  - ☐ Heart Valve Problem
- ☐ High Blood Pressure
- ☐ Human Immunodeficiency Virus (HIV)
- ☐ Immune Disorder Other than HIV
- ☐ Infertility/Reproductive Organ Disorder
  - ☐ Abnormal Pap Smear
  - ☐ Cervical Dysplasia
  - ☐ Enlarged Prostate/Prostatitis
  - ☐ Fibroid Uterus/Ovarian Cyst
- ☐ Kidney/Bladder/Urinary Disorder
  - ☐ Infections
  - ☐ Kidney Stones
  - ☐ Renal Failure
- ☐ Liver Disorder
  - ☐ Cirrhosis
  - ☐ Fatty liver
  - ☐ Hepatitis B
  - ☐ Hepatitis C
- ☐ Mental Impairment
- ☐ Mental/Nervous Disorder
  - ☐ Bipolar/Manic Depression
  - ☐ Depression/Eating Disorder
  - ☐ Drug or Alcohol Abuse
  - ☐ Schizophrenia
- ☐ Muscular Dystrophy
- ☐ Nervous System/Brain Disorder
  - ☐ Cerebral Palsy
  - ☐ Migraines/Cluster Headaches
  - ☐ Multiple Sclerosis
  - ☐ Parkinson's
  - ☐ Seizures/Epilepsy
  - ☐ Stroke
- ☐ Respiratory/Lung Disorder
  - ☐ Asthma
  - ☐ Bronchitis
  - ☐ Emphysema
- ☐ **None**
- ☐ Other conditions not listed above *(attach additional sheet, if needed)*: ______________

D) Do you, or any family member listed in Section 5, take any medicine(s), drugs, pills or herbs, or require shots? ☐ Yes ☐ No

**If you checked any items in Question C and/or answered "yes" to Question D, please complete the following** *(use additional application form, if necessary)*:

Additional form attached? ☐ Yes ☐ No

| Name of Person | Condition | Dates Diagnosed and Treated | Type of Treatment / Names of Medications | Current or Further Treatment? |
|---|---|---|---|---|
| | | | | |
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| ***Office Use Only*** | **Group #** | **Identification #** | **Effective Date** | **Package / Class #** | **Contract Type** |
|---|---|---|---|---|---|
| | | | | | |