Health Profile

for employer groups

BlueCross BlueShield Kansas

Please complete and return this questionnaire.

Thank you for completing this Health Profile. This information will help us create a quote for your health insurance.

Section 3 asks questions about health conditions. Don't be overly concerned about answering "yes" to a question. A "yes" answer does not 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.**

Please include complete information for each person in your family wanting health insurance. An incomplete Health Profile may need to be returned for more information and can delay your quote.

Your Health Profile Is confidential. Only authorized Blue Cross and Blue Shield of Kansas employees have access to your information. When you have completed this questionnaire, please return it to one of the addresses listed to the right. Thank you.

Employers
Please send your completed Health Profile to your group representative at Blue Cross and Blue Shield of Kansas.

Please begin on the next page.

Health Profile

for employer groups

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.

Section 1 – Applicant Information

CLEAR DATA

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

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

Residential Address ______ (____) ____-____ Home Phone Number (____) ____-____ Cell Phone Number

City ______ (____) ____-____ Work Phone Number (____) ____-____ Fax Number

State ______ ZIP Code ______ +4 ______ County ______ E-mail Address ______

Mailing Address (if different from residential address) ______ Married? ☐ Yes ☐ No If yes, give date of marriage. ____ /____ /____ Date of Marriage

City ______

State ______ ZIP Code ______ +4 ______

Section 2 – Spouse and Dependent Information

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 above (including applicant) gained entry to the U.S. through a VISA? ☐ Yes ☐ No

If yes, who and what type? ______

Please continue on the next page.

Section 3 – Health Statement Questionnaire

Does any person listed on this application use tobacco products or vape? ☐ No ☐ Current user ☐ Former user

If current or former user, please provide the user's name, the type of product(s) used, and quit date if applicable:

_____ ☐ Cigarette ☐ Pipe ☐ Cigar ☐ Chew/dip ☐ Vape _____ /_____ /_____
First Name Quit Date (if applicable)

_____ ☐ Cigarette ☐ Pipe ☐ Cigar ☐ Chew/dip ☐ Vape _____ /_____ /_____
First Name Quit Date (if applicable)

_____ ☐ Cigarette ☐ Pipe ☐ Cigar ☐ Chew/dip ☐ Vape _____ /_____ /_____
First Name Quit Date (if applicable)

In the past five years, has any person listed on this application been diagnosed with or treated for any of the conditions below? If yes, check the box next to the appropriate condition(s).

HEART, BLOOD OR CIRCULATORY CONDITIONS

☐ Coronary artery disease (narrowing, hardening)
☐ Congenital heart disorder
☐ Cardiomyopathy
☐ Heart arrhythmia (atrial fibrillation, flutter, bradycardia)
☐ Congestive heart failure
☐ Anemia
☐ Heart attack/myocardial infarction
☐ Heart valve disorder
☐ Hemophilia
☐ Thrombocytopenia (abnormally low platelets in blood)
☐ Hereditary angioedema
☐ High blood pressure – provide average of last three readings _____ /_____
☐ Other heart, blood or circulatory condition not listed: _____

If any condition above was checked "yes", please provide details below.

Person treated	Diagnosis	Details of treatment and/or condition	Physican name, city and state	Date physician last seen

DIGESTIVE SYSTEM CONDITIONS

☐ Bowel obstruction/blockage
☐ Irritable bowel syndrome
☐ Crohn's disease
☐ Pancreatitis (acute or chronic)
☐ Fatty liver disease
☐ Enlarged liver
☐ Non-alcoholic steatohepatitis (NASH)
☐ Enlarged spleen
☐ Cirrhosis of liver
☐ Chronic or relapsing pancreatitis
☐ Other digestive system condition not listed: _____

If any condition above was checked "yes", please provide details below.

Person treated	Diagnosis	Details of treatment and/or condition	Physican name, city and state	Date physician last seen

Please continue on the next page.

ENDOCRINE, LYMPHATIC, METABOLIC OR CHROMOSOMAL CONDITIONS

☐ Diabetes – Type 1

☐ Diabetes – Type 2

☐ Thyroid disorder

☐ Growth hormone deficiency

☐ Inherited metabolic disorder or chromosomal disorder (i.e., Gaucher's disease, familial hypercholesterolemia, Tay-Sachs disease, Pompe' disease, Fabry's disease, porphyria, Down's syndrome, Turner's syndrome, Marfan's syndrome, spinal muscular atrophy)

☐ Other endocrine, lymphatic or metabolic condition not listed: _____

If any condition above was checked "yes", please provide details below.

Person treated	Diagnosis	Details of treatment and/or condition	Physican name, city and state	Date physician last seen

MUSCLE, SKELETAL OR SKIN CONDITIONS

☐ Osteoarthritis (joint degeneration)

☐ Rheumatoid arthritis

☐ Psoriatic arthritis

☐ Osteoporosis

☐ Chronic skin ulcer

☐ Burn (50% or more of body)

☐ Psoriasis

☐ Orthopedic deformity (i.e., scoliosis, club foot, hip dysplasia)

☐ Systemic Lupus

☐ Other muscle, skeletal or skin condition not listed: _____

If any condition above was checked "yes", please provide details below.

Person treated	Diagnosis	Details of treatment and/or condition	Physican name, city and state	Date physician last seen

INFECTIOUS DISEASE CONDITIONS

☐ HIV/AIDS

☐ Hepatitis A, B or C

☐ Tuberculosis

☐ Immunodeficiency condition requiring Immune Globulin therapy

☐ Other infectious disease condition not listed: _____

If any condition above was checked "yes", please provide details below.

Person treated	Diagnosis	Details of treatment and/or condition	Physican name, city and state	Date physician last seen

Please continue on the next page.

NERVOUS SYSTEM CONDITIONS

☐ Stroke ☐ Transient Ischemic Attack (TIA) ☐ Parkinson's disease

☐ Alzheimer's disease ☐ Seizure disorder ☐ Spinal cord injury

☐ Brain injury ☐ Narcolepsy ☐ Cerebral palsy

☐ Amyotrophic Lateral Sclerosis (ALS) ☐ Multiple sclerosis

☐ Other nervous system condition not listed: _____

If any condition above was checked "yes", please provide details below.

Person treated	Diagnosis	Details of treatment and/or condition	Physican name, city and state	Date physician last seen

MENTAL HEALTH AND SUBSTANCE USE CONDITIONS

☐ Depression ☐ Anxiety ☐ Bipolar disorder

☐ Schizophrenia ☐ Autism ☐ Opioid dependence

☐ Anorexia Nervosa ☐ Bulimia

☐ Other substance abuse (i.e., alcohol, methamphetamine, marijuana)

☐ Other mental health or substance use condition not listed: _____

If any condition above was checked "yes", please provide details below.

Person treated	Diagnosis	Details of treatment and/or condition	Physican name, city and state	Date physician last seen

RESPIRATORY CONDITIONS

☐ Asthma ☐ COPD/Emphysema ☐ Pulmonary hypertension

☐ Pulmonary fibrosis ☐ Cystic fibrosis

☐ Other respiratory condition not listed: _____

If any condition above was checked "yes", please provide details below.

Person treated	Diagnosis	Details of treatment and/or condition	Physican name, city and state	Date physician last seen

Please continue on the next page.

URINARY, GENITAL AND REPRODUCTIVE CONDITIONS

☐ Kidney failure (acute) ☐ Kidney failure (chronic) ☐ Renal hypertension

☐ End Stage Renal Disease (ESRD)

☐ Other urinary, genital or reproductive condition not listed: _____

If any condition above was checked "yes", please provide details below.

Person treated	Diagnosis	Details of treatment and/or condition	Physican name, city and state	Date physician last seen

CANCER HISTORY

☐ Anal or rectal ☐ Bladder or kidney ☐ Bone

☐ Brain ☐ Breast ☐ Cervix or uterus

☐ Colon ☐ Esophagus ☐ Liver

☐ Lung ☐ Ovary ☐ Pancreas

☐ Prostate ☐ Melanoma ☐ Stomach

☐ Testicle ☐ Thyroid ☐ Tongue/mouth

☐ Leukemia ☐ Lymphoma ☐ Multiple myeloma

☐ Other cancer not listed: _____

If any condition above was checked "yes", please provide details below.

Person treated	Diagnosis	Details of treatment and/or condition	Physican name, city and state	Date physician last seen

Please continue on the next page.

Section 4 – Health Statement Questionnaire Follow-up

In the past 12 months, has any person listed on this application taken a prescription medication for more than 30 days? If yes, provide details below or attach print-out from pharmacy.

Person treated	Diagnosis	Medication name and dosage	Physican name, city and state	Date physician last seen

Is any person listed on this application currently pregnant or currently receiving infertility services? If yes, please provide details.

Person	Estimated date of delivery (if pregnant)	Single, twin, triplet or greater?	Physican name, city and state	Date physician last seen

In the past five years, has any person listed on this application received treatment or surgery at a hospital, medical facility or health care provider office for any condition **not listed above**? If yes, please provide details.

Person treated	Diagnosis (condition)	Details of treatment and/or condition	Physican name, city and state	Date physician last seen

Has any person listed on this application been advised to undergo medical treatment, surgical services, diagnostic testing or hospitalization **that is not already listed** in the next six months? If yes, please provide details.

Person to be treated	Condition being evaluated/treated	Type of planned service	Physican name, city and state	Date physician last seen

Please continue on the next page.

Section 5 – Important Information

Please read the following important statements and sign below in Section 6 to complete your health profile.

I understand that Blue Cross and Blue Shield of Kansas, Inc. (BCBSKS) will re-rate or terminate 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 health profile was incorrect; 2) if such information received at any time indicates the information provided in this health profile intentionally misrepresented a material fact or was fraudulent.

I understand no representative of BCBSKS has the authority to waive any information required on this health profile; 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 health profile 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. Note: Small groups with two or more employees enrolled in coverage are guaranteed issue. (A photographic copy of this authorization shall be as valid as the original.)

Section 6 – Authorization for the Release of Protected Health Information

I understand that by signing this health profile, 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 health profile 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 be 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 (Signature of parent/guardian required if applicant(s) is under age 18) Date Signed

_____

Print Name

For office use only

Sys. Number | Rep. Number | Date

Business Name