* Independent Licensees of the Blue Cross and Blue Shield Association.

Please complete and return within 5 days.

Your Health**Profile**

for individuals or businesses with 1 to 9 employees

Thank you for completing this Health Profile so we can provide a Custom Quote for your health insurance.

Section 2 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 Section 3.

Please include complete information for each person in your family wanting health insurance. (Dependents must be unmarried and under age 23, but need not be full-time students.) An incomplete Health Profile may need to be returned for more information and 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, seal it for return in the envelope provided. Thank you.

HealthProfile

For individuals or for businesses
with one to nine employees

For office use only

Sys. Number | Rep. Number | Date

Business Name

Section 1

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.

Name _____ Last _____ First _____ MI

Address _____ Street

_____ City _____ State _____ ZIP Code + 4

Home Phone (_____) _____ Area Code Daytime Phone (_____) _____ Area Code

Cell Phone (_____) _____ Area Code Fax (_____) _____ Area Code

Married? ☐ Yes ☐ No Date of marriage _____/_____/_____ MM DD YYYY Email Address _____

Applicant

Social Security No. _____ Date of Birth _____/_____/_____ MM DD YYYY

Gender ☐ Male ☐ Female Height _____ Weight _____

Spouse

Name _____ Last _____ First _____ MI

Social Security No. _____ Date of Birth _____/_____/_____ MM DD YYYY

Gender ☐ Male ☐ Female Height _____ Weight _____

Dependent (Must be unmarried, under age 23 and a dependent either naturally, through adoption, as a stepchild, or you must have legal guardianship.)

Name _____ Last _____ First _____ MI

Social Security No. _____ Date of Birth _____/_____/_____ MM DD YYYY

Gender ☐ Male ☐ Female Height _____ Weight _____

Relationship to Applicant ☐ Child ☐ Stepchild ☐ Other

Dependent (Must be unmarried, under age 23 and a dependent either naturally, through adoption, as a stepchild, or you must have legal guardianship.)

Name _____ Last _____ First _____ MI

Social Security No. _____ Date of Birth _____/_____/_____ MM DD YYYY

Gender ☐ Male ☐ Female Height _____ Weight _____

Relationship to Applicant ☐ Child ☐ Stepchild ☐ Other

Dependent (Must be unmarried, under age 23 and a dependent either naturally, through adoption, as a stepchild, or you must have legal guardianship.)

Name _____ Last _____ First _____ MI

Social Security No. _____ Date of Birth _____/_____/_____ MM DD YYYY

Gender ☐ Male ☐ Female Height _____ Weight _____

Relationship to Applicant ☐ Child ☐ Stepchild ☐ Other

Section 2

yes	no	
		Please check the boxes "yes" or "no". For each answer marked "yes", circle the condition and explain in Section 3 below:
☐	☑	**1. Do you or any dependent currently smoke?** If yes, who? _____
		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, please provide average of last 3 readings ____/____)
☐	☐	c. lungs or respiratory problems?
☐	☐	d. disorders of the kidneys or reproductive organs?
☐	☐	e. disorder of the liver, gallbladder, intestines, rectum, stomach or other vital organs?
☐	☐	f. diabetes or high blood sugar? If yes, please provide A1C reading _____
☐	☐	g. neurological disorder, stroke, physical incapacitation or seizures? If yes, 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 to include 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 person 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 time period? (include treatment dates below)
☐	☐	**4.** Are 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?

Section 3

Explain conditions in detail for any "yes" responses in section 2. Omitted information may cause delays. If additional space is needed, please attach a separate sheet.

Question no.	Person treated	Diagnosis or details about condition, treatment, medication name & dosage	Date diagnosed/ treated	Date physician last seen	Is further treatment recommended?	Physician name, city and state
					☐ yes ☐ no	
					☐ yes ☐ no	
					☐ yes ☐ no	
					☐ yes ☐ no	
					☐ yes ☐ no	

Section 4

Important Information

To Certify Your Health Profile

Please read the following important statements and **sign below to complete your health profile.**

- I understand any policy issued to me will be issued in reliance upon the information I have provided on this health profile.
- 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 health profile was incorrect; 2) if such information received at any time indicates the information provided in this health profile was materially misstated or was fraudulent.
- For Advance Insurance Company of Kansas (AICK), no misrepresentation made in obtaining or securing a policy of insurance on the life or lives of any person or persons, citizens of this state, shall be deemed material or render the policy void unless the matter misrepresented shall have actually contributed to the contingency or event on which the policy is to become due and payable.
- I understand no representative of BCBSKS or AICK 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 (and my spouse's, if applicable) verify that I (we) have read all of the information on this form and certify that it is correct and accurate. I understand BCBSKS or AICK 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 or AICK.
- **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. (A photographic copy of this authorization shall be as valid as the original.)**

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 or AICK.
- 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.
- I further understand that by signing this health profile, I authorize BCBSKS to disclose any and all health information they possess or obtain about me or about my dependents covered by this health profile to AICK for the purpose of determining initial or continuing eligibility for coverage and that BCBSKS conditions payment, enrollment, and eligibility of benefits on my authorizing such disclosures.
- This authorization is valid until the termination of health insurance coverage with BCBSKS or until such time as written revocation is received by BCBSKS. 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 _____ Date ____/____/____

(Signature of parent/guardian required if applicant(s) under age 18)

Print Your Name _____

Your Spouse's Signature (if applicable) _____ Date ____/____/____