Wellmark

Wellmark Blue Cross Blue Shield of Iowa
Wellmark Health Plan of Iowa, Inc.

Independent Licensees of the Blue Cross and Blue Shield Association

PO Box 14527 • Des Moines, Iowa 50306-3527

Application for Individual Health & Dental Insurance

(For plans effective 1/1/2015 and after)

Clear

DIRECTIONS

- If you are applying for a new policy during Open Enrollment, complete Sections A, B, C, D, E, H (if applicable), and I.
- If you are applying for a new policy due to a Special Enrollment Event, complete all sections.

A. MEMBERSHIP INFORMATION

Effective date: _____/_____/_____. Effective dates of coverage will be determined based on rules in Section I.

Applicant Name (First, Middle, Last, Suffix)

Marital Status: ☐ Single ☐ Married, including common-law ☐ Domestic Partner (Domestic Partnership Certification required)

Physical Address
Address Line 1 (Street Address or Apt./Suite #)_____

Address Line 2 (PO Box, Street Address)_____

City_____ State_____ ZIP_____

Mailing Address (Please complete if different than physical address)
Address Line 1 (Street Address or Apt./Suite #)_____

Address Line 2 (PO Box, Street Address)_____

City_____ State_____ ZIP_____

Daytime Phone: ( )

Other Phone: ( )

Email (optional):

Provide name of county in which applicant resides:

List all persons to be covered		Birthdate	Social Security Number / Tax Identification Number[1]	Gender	Full-time Student?[2]	Disabled?[2]	Tobacco User?[3]
Name (First, MI, Last)	Relationship to Applicant						
Applicant	Self			☐ M ☐ F	N/A	☐ Yes ☐ No	☐ Yes ☐ No
Spouse or Domestic Partner	Spouse or Domestic Partner[4]			☐ M ☐ F	N/A	☐ Yes ☐ No	☐ Yes ☐ No
Dependent 1				☐ M ☐ F	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Dependent 2				☐ M ☐ F	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Dependent 3				☐ M ☐ F	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Dependent 4				☐ M ☐ F	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

[1]A Social Security Number (SSN) or Tax Identification Number (TIN) must be provided for you and every covered member for timely processing. Further review may be necessary if an SSN or TIN is not provided.
[2]Disabled dependents and full-time students age 26 or older must be unmarried to be eligible for coverage as a dependent.
[3]Applies to anyone listed on this application age 18 and over. Answer "yes" if, with the exception of religious or ceremonial purposes, the person listed has used any form of tobacco on average of four or more times per week within the past six months.
[4]Domestic Partnership Certification required.

For Office Use Only	Date Received

Applicant Name (First, Middle, Last)	Social Security Number/Tax Identification Number

A. MEMBERSHIP INFORMATION, CONT'D

1. If you listed a dependent above who is an unmarried student age 26 or older, please provide name of school that this student is attending: _____

   _____ Date student entered school: _____/_____/_____

2. ☐ Yes ☐ No Are you the parent or legal guardian and/or have power of attorney (POA) for the individual listed above?

   If yes, check appriopriate box: ☐ Parent ☐ Legal Guardian ☐ Power of Attorney (POA)

   First Name _____ MI _____ Last Name _____ Suffix _____

   What is your relationship to that person? _____

   If your mailing address is different than the applicant's mailing address, please provide your mailing address:

   Address Line 1 (Street Address or Apt./Suite #)_____

   Address Line 2 (PO Box, Street Address) _____

   City _____ State _____ Zip _____

   County _____

   Note: If applicable, please provide the legal documentation.

3. ☐ Yes ☐ No Does your spouse/domestic partner or any of the dependents listed on this application have a different mailing address than the applicant's mailing address? If yes and not already provided above, please complete the following:

   Spouse/Domestic Partner/Dependent Name _____

   Address Line 1 (Street Address or Apt./Suite #)_____

   Address Line 2 (PO Box, Street Address) _____

   City _____ State _____ Zip _____

   Note: If you need to list more than four dependents or have additional legal guardianship, power of attorney, or address information, please use Section H of application to provide that additional information.

In order to complete the enrollment process as soon as possible, Wellmark may need to contact you. Please list daytime phone numbers or other phone numbers for dependents if different than the applicant's phone numbers. (Optional)

Relationship to Applicant	Daytime Phone Number	Other Phone Number	Relationship to Applicant	Daytime Phone Number	Other Phone Number
Spouse or Domestic Partner			Dependent 3		
Dependent 1			Dependent 4		
Dependent 2					

B. MEDICARE COVERAGE

☐ Yes ☐ No Are you and/or any listed in section A enrolled in Medicare?
If yes, complete the following as appropriate:

Applicant Name (as it appears on Medicare card): _____ Medicare ID (HIC) No: _____

Effective Date (Part A): _____/_____/_____ Effective Date (Part B): _____/_____/_____ Effective Date (Part C): _____/_____/_____

Spouse or Domestic Partner Name (as it appears on Medicare card): _____ Medicare ID (HIC) No: _____

Effective Date (Part A): _____/_____/_____ Effective Date (Part B): _____/_____/_____ Effective Date (Part C): _____/_____/_____

Dependent Name (as it appears on Medicare card): _____ Medicare ID (HIC) No: _____

Effective Date (Part A): _____/_____/_____ Effective Date (Part B): _____/_____/_____ Effective Date (Part C): _____/_____/_____

Applicant Name (First, Middle, Last)	Social Security Number/Tax Identification Number

C. ENROLLMENT INFORMATION

1. Select your health plan option by placing a check mark in the box prior to your choice.

The following are underwritten by Wellmark Blue Cross and Blue Shield of Iowa:

SimplyBlue℠	CompleteBlue℠	EnhancedBlue℠	myBlue HSA℠
☐ 5500	☐ 2500 ☐ Max 5000 ☐ 3000 B (PPO) ☐ 50/50 ☐ 4000	☐ 500 ☐ 1500 ☐ 1250 ☐ Max 2750 B (PPO)	☐ 2000 ☐ 3000 B (PPO) ☐ 5300

The following are underwritten by Wellmark Health Plan of Iowa, Inc.:

SimplyBlue℠	CompleteBlue℠	EnhancedBlue℠	myBlue HSA℠	Blue Rewards℠
☐ 4750 ☐ 5000	☐ 3000 A (HMO) ☐ Max 4500	☐ Max 2750 A (HMO)	☐ 3000 A (HMO)	☐ 1000 ☐ 5000 ☐ 1500

If I have elected a health plan option offered by Wellmark Health Plan of Iowa, Inc., I will ensure the plan I've selected is offered in my county. [To verify if a county is participating, visit Wellmark.com/BlueRewards or contact an agent.] ☐ **Yes**

If selecting myBlue HSA℠ coverage, would you like assistance setting up a Health Savings Account (HSA)? ☐ Yes ☐ No **If "yes" is selected, Social Security number (SSN) must be provided on this application.**

Selecting "yes" for the Health Savings Account (HSA) option authorizes Wellmark, Inc. to share the following information with U.S. Bank for the purposes of establishing an HSA. **Information to be disclosed to U.S. Bank includes: your name, address, phone number, email address, date of birth, and Social Security Number. Not providing an email address will delay the process.** See additional information in Section I.

The Summary of Benefits and Coverage you have received or will be receiving includes important information about the Wellmark coverage available to you. In addition, there is important information available to you at *Wellmark.com/Inform* that addresses a number of topics such as Wellmark's guidelines on investigational and experimental procedures, the methodologies Wellmark uses to compensate providers, and information on how to access Wellmark's internal claims appeal and external review process. You can also obtain this information by calling Wellmark Customer Service at 800-978-3221.

2. Select your optional benefits by placing a check mark in the "yes" or "no" box after each optional benefit. If you do not check "yes" or "no" for each optional benefit, you and your dependents, if applicable, will not be enrolled in optional benefit coverage.

Blue Dental℠ ☐ Yes ☐ No

Supplemental Accident ☐ Yes ☐ No
(May only be selected if you have selected a health plan other than a myBlue HSA plan.)

Vision/Hearing (Avesis/EPIC*) ☐ Yes ☐ No
*Avesis Vision is an independent vision insurance company that does not provide Wellmark products and services. Avesis Vision is underwritten by Fidelity Security Life Insurance Company, Kansas City, Missouri. EPIC Hearing Healthcare, which provides the Hearing Discount Savings Plan, does not provide Wellmark products and services.

Primary Care Provider Information (PCP): Complete if you selected a plan underwritten by Wellmark Health Plan of Iowa, Inc. (If you need to provide information for more than four dependents, please provide that information on a separate sheet of paper and attach to this application.)

For each person named in Section A and H, complete the following information:

Applicant
Provider Name: _____
Provider Address Line 1 (Street Address or Apt/Suite#): _____
Provider Address Line 2 (PO Box, Street Address): _____
City: _____ State: _____ ZIP: _____
☐ Yes ☐ No Are you an established patient?
OB/GYN Name (optional): _____
Provider Address Line 1 (Street Address or Apt/Suite#): _____
Provider Address Line 2 (PO Box, Street Address): _____
City: _____ State: _____ ZIP: _____
☐ Yes ☐ No Are you an established patient?

Spouse or Domestic Partner
Provider Name: _____
Provider Address Line 1 (Street Address or Apt/Suite#): _____
Provider Address Line 2 (PO Box, Street Address): _____
City: _____ State: _____ ZIP: _____
☐ Yes ☐ No Are you an established patient?
OB/GYN Name (optional): _____
Provider Address Line 1 (Street Address or Apt/Suite#): _____
Provider Address Line 2 (PO Box, Street Address): _____
City: _____ State: _____ ZIP: _____
☐ Yes ☐ No Are you an established patient?

Dependent 1
Provider Name: _____
Provider Address Line 1 (Street Address or Apt/Suite#): _____
Provider Address Line 2 (PO Box, Street Address): _____
City: _____ State: _____ ZIP: _____
☐ Yes ☐ No Are you an established patient?
OB/GYN Name (optional): _____
Provider Address Line 1 (Street Address or Apt/Suite#): _____
Provider Address Line 2 (PO Box, Street Address): _____
City: _____ State: _____ ZIP: _____
☐ Yes ☐ No Are you an established patient?

Dependent 2
Provider Name: _____
Provider Address Line 1 (Street Address or Apt/Suite#): _____
Provider Address Line 2 (PO Box, Street Address): _____
City: _____ State: _____ ZIP: _____
☐ Yes ☐ No Are you an established patient?
OB/GYN Name (optional): _____
Provider Address Line 1 (Street Address or Apt/Suite#): _____
Provider Address Line 2 (PO Box, Street Address): _____
City: _____ State: _____ ZIP: _____
☐ Yes ☐ No Are you an established patient?

Applicant Name (First, Middle, Last)	Social Security Number/Tax Identification Number

Primary Care Provider Information (PCP) (CONT'D): Complete if you selected a plan underwritten by Wellmark Health Plan of Iowa, Inc. (If you need to provide information for more than four dependents, please provide that information on a separate sheet of paper and attach to this application.)

For each person named in Section A and H, complete the following information (CONT'D):

Dependent 3

Provider Name: _____

Provider Address Line 1 (Street Address or Apt/Suite#): _____

Provider Address Line 2 (PO Box, Street Address): _____

City: _____ State: _____ ZIP: _____

☐ Yes ☐ No Are you an established patient?

OB/GYN Name (optional): _____

Provider Address Line 1 (Street Address or Apt/Suite#): _____

Provider Address Line 2 (PO Box, Street Address): _____

City: _____ State: _____ ZIP: _____

☐ Yes ☐ No Are you an established patient?

Dependent 4

Provider Name: _____

Provider Address Line 1 (Street Address or Apt/Suite#): _____

Provider Address Line 2 (PO Box, Street Address): _____

City: _____ State: _____ ZIP: _____

☐ Yes ☐ No Are you an established patient?

OB/GYN Name (optional): _____

Provider Address Line 1 (Street Address or Apt/Suite#): _____

Provider Address Line 2 (PO Box, Street Address): _____

City: _____ State: _____ ZIP: _____

☐ Yes ☐ No Are you an established patient?

☐ I certify that I am legally authorized to assign a PCP for myself and for all other persons named in this section.

3a. Will your employer be paying any part of the premium or fee for this policy either directly or through wage adjustments or other means of reimbursement?
☐ Yes ☐ No

3b. Will your premium and fee payments for this coverage be deductible on your federal income tax return as a trade or business expense other than the special health insurance deduction available to self-employed persons? ☐ Yes ☐ No

If you answered yes to either 3a or 3b, check one item below:

☐ Applicant is owner of a sole proprietor business
☐ Employer is deducting the full premium and fee
☐ Employee is part-time or temporary
☐ Employer has been denied the opportunity to purchase insurance due to low participation/contribution (attach copy of denial)

D. CONCURRENT/OTHER COVERAGE - READ SECTION G "NOTICE TO APPLICANT REGARDING REPLACEMENT OF ACCIDENT AND SICKNESS INSURANCE"

1a. ☐ Yes ☐ No Will you, your spouse/domestic partner, or your dependents keep other coverage in addition to this Wellmark coverage?
If you answered "yes," please complete information below. (If other coverage is provided by a Blue Cross and Blue Shield carrier in another state, provide that carrier's name and state.)

Other Insurance Carrier Name _____ Other Insurance ID Number _____

Other Insurance Carrier Address Line 1 (Street Address or Apt/Suite#) _____

Other Insurance Carrier Address Line 2 (PO Box, Street Address) _____

City _____ State _____ ZIP _____

Policyholder for Other Insurance _____ Policyholder Date of Birth _____/_____/_____

Effective Date of Other Insurance _____/_____/_____ Termination Date of Other Insurance _____/_____/_____

Covered Individuals _____

Name of person who has primary responsibility for the dependents, if applicable _____

1b. ☐ Yes ☐ No Are you, your spouse/domestic partner, or any dependents covered under any other plan pursuant to a court order?

2a. ☐ Yes ☐ No Are you, or anyone listed on your policy, covered by an existing Wellmark health or Blue Dental plan?

2b. If yes, did you:

☐ Buy your health insurance directly from Wellmark or through an agent? **If so, go to question 2c.**
☐ Get health insurance through an employer? (If you have health insurance through an employer, please contact that employer to make changes or to cancel the policy.) **If so, go to Section E. Payment Information.**

2c. ☐ Yes ☐ No Do you want Wellmark to cancel your existing individual plan after you're enrolled in the coverage on this application?

If yes, please provide the ID number on your card _____

If no, your current Wellmark individual coverage will not be terminated, and you will be billed for your current coverage in addition to your new coverage.

Please note: By choosing to cancel your existing individual plan, all of your plans - including Blue Dental - may be cancelled.

To remove a member(s) but not cancel the entire policy, please complete an Individual Health Plan Contract Change Form.

Please note: If you are not listed as the policy holder on the existing individual plan, the policy holder must send Wellmark an Individual Health Plan Contact Change Form with his or her signature to approve the cancellation or change.

Applicant Name (First, Middle, Last)	Social Security Number/Tax Identification Number

E. PAYMENT INFORMATION

How do you want to pay for your total monthly premium and fees? **Please do not send payment with this application.**

Note: All billing periods are based on a calendar year.

☐ 1. **Direct Bill.** If so, on what basis? ☐ Semi-annually ☐ Annually

☐ 2. **Automatic Account Withdrawal from Applicant's account.**

☐ 3. **Automatic Account Withdrawal from account other than Applicant's.**

If you checked 2 or 3, please complete the following:

If so, on what basis? ☐ Monthly ☐ Quarterly ☐ Semi-annually ☐ Annually

Date of withdrawal: ☐ 1st of the month ☐ 5th of the month

From: ☐ Checking

☐ Savings *(If you want to have premiums and fees withdrawn from your savings account, please complete Form M-5779.)*

Attach a voided check OR complete the following information:

Bank Account Name(s) (exactly as it appears on the account) _____

Account Number _____

Financial Institution Routing Number (9 digits) _____

Financial Institution Name _____

Branch Address Line 1 (Street Address or Apt/Suite#) _____

Branch Address Line 2 (PO Box, Street Address) _____

City _____ State _____ ZIP _____

If payer's billing address is different than the applicant's name and mailing address, please complete the following:

Payer Name (First Name, MI, Last Name, Suffix) _____

Address Line 1 (Street Address or Apt./Suite #) _____

Address Line 2 (PO Box, Street Address) _____

City _____ State _____ ZIP _____

If Direct Bill is ***not*** selected:

I hereby authorize Wellmark to make automatic withdrawals from the account shown in the amount of my periodic premium payment and fee, if applicable, as they may be adjusted from time to time. I hereby certify that I have read and understand the provisions of the Application Agreement and Certification section below, and specifically the sub-section entitled "Payment Arrangements." This authorization shall supersede and replace any previous authorization given by me for automatic premium withdrawal. ☐ Yes

You may cancel automatic account withdrawal at any time. However, we need to receive your written notification by the 10th of the month before your next scheduled withdrawal.

F. SPECIAL ENROLLMENT EVENTS

1a. Select qualifying event from the list below by placing a check mark in box prior to applicable event:

- ☐ Birth
- ☐ Adoption, placement for adoption or foster care
- ☐ Involuntary loss of employer coverage or employer contribution
- ☐ Involuntary loss of creditable coverage
- ☐ Permanent move to Iowa
- ☐ Marriage
- ☐ Court-ordered coverage
- ☐ Returning from military service
- ☐ Domestic Partnership
- ☐ Qualifying event not listed_____

1b. List date of event _____/_____/_____

2. ☐ Yes ☐ No Does any person named on this application have qualifying previous coverage(s)?

If you answered "yes," please provide prior insurance information below. (If prior coverage is/was provided by a Blue Cross and Blue Shield carrier in another state, indicate the carrier name, issuing state, and termination date.)

Prior Insurance Company Name _____

ID Number _____

Termination Date _____/_____/_____

Covered Individuals _____

Applicant Name (First, Middle, Last)	Social Security Number/Tax Identification Number

G. NOTICE TO APPLICANT REGARDING REPLACEMENT OF ACCIDENT AND SICKNESS INSURANCE

If this coverage is intended to replace any health coverage currently in force:

a. You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your current policy. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.

b. After the application has been completed and before you sign it, reread it carefully to be certain that all information has been properly recorded.

H. ADDITIONAL INFORMATION

If you need to list any additional dependents, please provide that information below:

Name (First, MI, Last)	Birthdate	Social Security Number/ Tax Identification Number[1]	Gender	FT Student?[2]	Disabled?[2]	Tobacco User[3]
Dependent			☐ M ☐ F	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Dependent			☐ M ☐ F	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Dependent			☐ M ☐ F	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Dependent			☐ M ☐ F	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Dependent			☐ M ☐ F	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

[1]A Social Security Number (SSN) or Tax Identification Number (TIN) must be provided for you and every covered member for timely processing. Further review may be necessary if an SSN or TIN is not provided.
[2]Disabled dependents and full-time students age 26 or older must be unmarried to be eligible for coverage as a dependent.
[3]Applies to applicant, spouse/domestic partner, and any dependents age 18 and over. Answer "yes" if, with the exception of religious or ceremonial purposes, the person listed has used any form of tobacco on average of four or more times per week within the past six months.

If you need to provide legal guardianship, POA information or additional mailing addresses for any of your dependents, please provide information below:

Dependent Name _____

☐ Mailing address is different than Primary Applicant's mailing address

Address Line 1 (Street Address or Apt./Suite #) _____

Address Line 2 (PO Box or Street Address) _____

City _____ State _____ Zip _____

Daytime Phone (optional): _____ Other Phone (optional): _____

Please check box as appropriate: ☐ Legal Guardian ☐ POA

First Name _____ MI _____ Last Name _____ Suffix _____

Address Line 1 (Street Address or Apt./Suite #) _____

Address Line 2 (PO Box or Street Address) _____

City _____ State _____ Zip _____

Dependent Name _____

☐ Mailing address is different than Primary Applicant's mailing address

Address Line 1 (Street Address or Apt./Suite #) _____

Address Line 2 (PO Box or Street Address) _____

City _____ State _____ Zip _____

Daytime Phone (optional): _____ Other Phone (optional): _____

Please check box as appropriate: ☐ Legal Guardian ☐ POA

First Name _____ MI _____ Last Name _____ Suffix _____

Address Line 1 (Street Address or Apt./Suite #) _____

Address Line 2 (PO Box or Street Address) _____

City _____ State _____ Zip _____

Applicant Name (First, Middle, Last)	Social Security Number/Tax Identification Number

H. ADDITIONAL INFORMATION, CONT'D

Dependent Name _____

☐ Mailing address is different than Primary Applicant's mailing address

Address Line 1 (Street Address or Apt./Suite #) _____

Address Line 2 (PO Box or Street Address) _____

City _____ State _____ Zip _____

Daytime Phone (optional): _____ Other Phone (optional): _____

Please check box as appropriate: ☐ Legal Guardian ☐ POA

First Name _____ MI _____ Last Name _____ Suffix _____

Address Line 1 (Street Address or Apt./Suite #) _____

Address Line 2 (PO Box or Street Address) _____

City _____ State _____ Zip _____

I. APPLICATION AGREEMENT AND CERTIFICATION

I certify that I am legally authorized to apply for coverage for myself and on behalf of all other persons named in this application. I understand that I am applying for the Health Plan Options indicated on this application which are underwritten either by Wellmark, Inc., doing business as Wellmark Blue Cross and Blue Shield of Iowa, or Wellmark Health Plan of Iowa, Inc. (collectively, "Wellmark"). I further understand that coverage applied for will not start until this application and the appropriate premium amount is received and accepted by Wellmark, an effective date of coverage is established, and Wellmark reviews and approves this application and notifies me in writing of approval of coverage.

If applicable, for my convenience I authorize Wellmark to automatically utilize existing policyholder information for me and any dependents from my current policy to complete an electronic application for the plan indicated by me in Section C above. I authorize my Wellmark representative to enter the plan information on this form in Wellmark's electronic application and to submit the application including any automatically pre-populated information on my behalf.

If I am electing Health Plan Options offered by Wellmark Health Plan of Iowa, Inc., I understand that as a condition of eligibility for benefits under the coverage specified in this application, each person named in this application must maintain his/her residency in an Iowa county offering the plan I've selected. I understand that some of Wellmark's plans are not available in all counties. Failure to maintain such residency by any person named in this application will give Wellmark Health Plan of Iowa, Inc. the right to terminate the coverage specified in this application for that person not maintaining residency by giving that person not less than thirty (30) days notice in advance of termination of coverage and benefits will be denied unless the medical services are related to emergency services or an accidental injury.

The statements and answers set forth in this application are full, true, and correct. I have consulted with each other person named in this application to confirm that information about them is full, true, and correct. I understand that Wellmark will rely on the completeness and truthfulness of the information given in the statements made in this application or by telephone or in writing to Wellmark, and that if I performed an act, practice, or omission that constitutes fraud or I have made an intentional misrepresentation of material fact in this application, Wellmark will be entitled to declare coverage applied for void and to refuse allowance of benefits to any person thereunder.

Coverage Effective Date
The coverage effective date will be assigned according to Wellmark guidelines. For special enrollment events, Wellmark must be notified within 60 days of the event (or 120 days of returning from military service). The coverage effective date for special enrollment events will be the 1st of the month following the event. Exceptions are birth, adoption, placement for adoption, legal guardianship, court-ordered coverage, and foster child placement; for these events, coverage effective date is the date of the event.

Tobacco User Status
If I answered "No" to the Tobacco Declaration for any person age 18 and over listed on this application, that person is eligible for a special tobacco non-user rate. If this status changes, I must notify Wellmark immediately. Wellmark may require me to recertify this status in the future. If Wellmark determines within the initial two years that this status is incorrect, Wellmark will retroactively collect historical differences in premiums before claims will be paid and the tobacco user rate will be applied on the first of the month following receipt of this information.

Eligibility
If I become enrolled in Medicare during the term of this benefits policy, I understand that this benefits policy will provide benefits secondary to Medicare unless application of federal law determines this benefit policy must provide benefits primary to Medicare.

Dental Exclusion Periods
In the event I have selected Blue Dental℠ coverage on this application, which is underwritten by Wellmark, Inc., doing business as Wellmark Blue Cross and Blue Shield of Iowa, I certify that I have been informed that there will be a six-month exclusion period before benefits are available for basic restorative services including, but not limited to, fillings, extractions, and oral surgery, and a 12-month exclusion period before benefits are available for major restorative services including, but not limited to, endodontics, periodontics, crowns, onlays, and inlays. I understand these dental coverage exclusion periods may not be waived or reduced even if I or any other person named in this application have qualifying existing coverage or qualifying previous coverage.

myBlue HSA℠
In the event I have selected myBlue HSA℠ coverage on this application, I understand that enrolling in myBlue HSA℠ coverage does not guarantee that I am or will be eligible to make contributions to a health savings account or that contributions can be made to a health savings account on my behalf. I understand that child-only contracts are not eligible for health savings accounts.

If I answered "yes" in Section C above to authorize U.S. Bank to contact me, I understand I will receive guidelines and instruction from U.S. Bank for completing the opening of my HSA account. I will review enrollment materials carefully; it is the individual's responsibility to validate eligibility for an HSA account. Questions regarding eligibility can be directed to U.S. Bank.

Applicant Name (First, Middle, Last)	Social Security Number/Tax Identification Number

I. APPLICATION AGREEMENT AND CERTIFICATION

This authorization is voluntary. Wellmark will not condition my enrollment in a health plan, eligibility for benefits or payment of claims on giving this authorization. The information described above will be disclosed to an organization that is not subject to federal health information privacy laws and may be re-disclosed. The authorization will remain in effect until my information is submitted to U.S. Bank. I may revoke this authorization at any time by giving written notice to Wellmark, Inc. The revocation of this authorization will not affect any information disclosed to U.S. Bank before the revocation was received.

Release of Medical Information
I authorize any health care provider, including but not limited to; surgeon, physician, psychologist, nurse, social worker, or health care facility to release to Wellmark all health and mental health records protected by Federal or State law relating to AIDS or AIDS related complex, mental health and substance abuse, the past, present, or future treatments or conditions for myself or for my dependents eligible for health care coverage. I further agree upon request to furnish Wellmark with information required to administer the requested coverage.

I understand that I have the right to revoke this authorization in writing at any time by delivering such written notification to the requestor. I understand that a revocation is not effective until received by the requestor. I further understand that any revocation is not effective to the extent that Wellmark or the Provider have relied on it in the use or disclosure of protected health information.

This form does not authorize the redisclosure of medical information. Federal and State regulations do not allow further disclosure of mental health, substance abuse and AIDS/HIV related information. Wellmark maintains the confidentiality of **all** information received and it will not be released to any person or facility.

The protected health information described above may be disclosed to and/or received by persons or organizations that are not health plans, covered health care providers or health care clearinghouses subject to federal health information privacy laws. They may further disclose the protected health information, and it may no longer be protected by federal health information privacy laws.

I understand that I have the right to refuse to sign this authorization, but that Wellmark will then have the right to condition eligibility determination and enrollment on the receipt of this signed authorization.

Providing Social Security Numbers or Tax Identification Numbers
In order for Wellmark to report your coverage status to the federal government, you must provide to us your Social Security number or tax identification number and the Social Security numbers or tax identification numbers of all members covered under your coverage. The IRS requires that Wellmark report this information using the Social Security number or tax identification number of the plan member and each dependent. If Wellmark does not have Social Security or tax identification numbers, we will be unable to report and send the information needed to complete federal tax returns. If you have not previously provided your Social Security number or tax identification number to Wellmark for all members covered under your coverage, you should contact us by calling the Customer Service number on your ID card. If you do not provide the Social Security numbers or taxpayer identification numbers to Wellmark for this purpose, you may be subject to a $50 penalty per violation imposed by the Internal Revenue Service.

Payment Arrangements
Payments for premiums and fees may be made on a calendar month, calendar quarter, semi-annual calendar year or calendar year basis. For example, a monthly payment for premiums and fees would be for the first day of a month through the last day of such month. A quarterly payment would be for any calendar quarterly period, such as January 1 through March 31. A semi-annual payment would be for the period of either January 1 through June 30 or July 1 through December 31. An annual payment would be for January 1 through December 31 of the applicable year.

In the event I choose to pay my premium and fees on a quarterly, semi-annual, or annual basis and there is a mid-year increase in the amount of premium(s) and/or fees, I will have the following responsibility with regard to an increase in premium(s) and fees:

- Quarterly Payments: For quarterly payments, I must pay the remaining quarterly premium and fee payment that includes the premium and fee increase.
- Semi-Annual Payments: For semi-annual payments, I must pay a bill for a premium and fee payment that equals the difference between the new semi-annual premium and fee amount and the previously paid first semi-annual premium and fee amount. I also will be required to pay a second semi-annual premium and fee amount that includes the premium and fee increase.
- Annual Payment: For annual payments, I must pay a bill for a premium and fee payment that equals the difference between the new annual premium and fee amount and the previously paid annual premium and fee amount.

I understand and agree that Wellmark can change my payment amount at any time and the amount of my periodic premium payment and fee payment, will change as provided in the policy being applied for and from time to time based on changes in my coverage, including but not limited to, changes in benefits, payment obligations (such as deductible, coinsurance and copayments), the number of covered family members, members' ages, changes in tobacco user status, or other factors that require adjustments to the total premium and fees. These changes may occur at times other than an annual or other policy renewal.

If I have elected to authorize automatic premium withdrawals for payment from a deposit account, I understand that, depending upon the timing of when my application is received and processed, Wellmark reserves the right to withdraw the appropriate amount necessary (including multiple months of payments) to bring my account current with the next regularly scheduled automatic payment. Wellmark will not withdraw any amount above that which is due at the time of withdrawals. Notice may not be provided to me prior to this withdrawal. I understand and agree that I will not receive a paper billing statement but that should I want to be notified of amounts being withdrawn, I can do so by viewing my bill on *Wellmark.com* prior to my chosen withdrawal date. By visiting *Wellmark.com*, I can also choose to subscribe to an email notifying me when new billing statements are available which will include my withdrawal amount.

I further understand and agree that the automatic withdrawal will change periodically to correspond with the applicable premium and fees. My authorization for automatic withdrawals shall include authorization for automatic withdrawal of any changed amount unless I call or provide my bank with written notice not less than three (3) business days before a scheduled withdrawal to stop the payment. If I call my bank to stop payment, I may be required to provide a written request within fourteen (14) days after my call. I will be responsible for any fee assessed by my bank for stop-payment orders that I make. I may also be charged a returned payment fee of $25 for any automatic withdrawal that is not honored by my bank.

I also understand and agree that, if I am applying for coverage within 60 days of a premium change with an effective date prior to the premium change, Wellmark will provide notice of the new rate within a reasonable period of time after the enrollment of my application.

Coverage Renewability
I understand that coverage is automatically renewed by payment of my premium and fees in advance; that a grace period of 31 days will be granted for the payment of each premium and fee due after the first premium and fees; and that, during this grace period, my policy will continue in force.

Applicant Name (First, Middle, Last)	Social Security Number/Tax Identification Number

I. APPLICATION AGREEMENT AND CERTIFICATION, CONT'D

I understand that Wellmark may terminate my policy if:

- I fail to pay my premium and fees when due; or
- I fraudulently use my policy or make an intentional misrepresentation of a material fact under the terms of my policy; or
- I become ineligible for coverage under this policy; or
- Wellmark decides to terminate coverage of similar policies by giving written notice prior to termination. In the event Wellmark terminates individual policies of the same coverage, I will be allowed to transfer to the offered replacement policy.
- I change my residence from the geographic service area served by Wellmark Health Plan of Iowa, Inc. if I am enrolling in a health plan option offered by Wellmark Health Plan of Iowa, Inc.

Acknowledgment

I have read and understand the Summary of Benefits and Coverage and each provision of this application, including, but not limited to the sections entitled "Notice to Applicant Regarding Replacement of Accident and Sickness Insurance" and "Application Agreement and Certification."

I acknowledge I have received a Summary of Benefits and Coverage with this application if completed online through *Wellmark.com*. If a Wellmark appointed insurance producer or Wellmark representative assisted me with the application process, I have been advised I will receive a Summary of Benefits and Coverage within seven business days following the date the insurance producer or Wellmark representative signs this application.

I understand that I am not able to apply for coverage outside of open enrollment unless I had a qualifying event. If I am enrolling outside of the annual open enrollment period, I attest that I am eligible for coverage based upon a qualifying event as specified in Section F. I understand that Wellmark can request additional documentation at any time to verify the special enrollment event.

I hereby confirm the authority of Wellmark to make automatic withdrawals from my deposit account as set forth above under "Payment Information," and that this authorization supersedes and replaces any previous authorization given by me with respect to such authority.

I have confirmed with all persons named in this application that my signature is binding to secure coverage. I have further confirmed with all persons named in the application that in the event I am not eligible for or removed from the coverage and/or the family coverage is divided into multiple policies, my signature is binding to secure coverage. Any payment will be deposited immediately upon Wellmark's receipt of this application.

The information in this application is correct to the best of my knowledge. I understand that if I intentionally provide false information in this application, I will be disenrolled from the plan.

My signature is considered valid whether I supplied it online electronically, by telephone, or on paper and has the same full force and effect as my written signature.

☐ I give permission to the licensed agent who is identified with this application to enter my application online through *Wellmark.com*. (Agent is required to retain original paper application for 10 + 1 years.)

Applicant SignatureX _____ Date: _____/_____/_____
If applicant is a minor, please sign below. (If legal guardian, please provide proof of guardianship)

Power of Attorney/Legal Guardian Printed Name _____

Power of Attorney/Legal Guardian SignatureX _____ Date: _____/_____/_____

Agent's Printed Name _____

Agent Signature X_____ Date: _____/_____/_____ Agent No. |___|___|___|___|___|___|___|___|___|___|

Agent Phone Number (optional) _____

Please do not send payment with this application. You will be billed or automatic withdrawal will be processed upon approval and enrollment.

This application must be signed within the annual open enrollment period or within a special enrollment period. If this application is received later than 15 days after your signature date, eligibility for requested coverage and effective date are subject to change.

Send all pages of this completed application to:

Wellmark Blue Cross and Blue Shield of Iowa
Station 3W190
PO Box 14527
Des Moines, IA 50306-3527

OR

Fax to: 515-376-9045

OR

Email to INDMEMMAIN@WELLMARK.COM