



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

Independent Licensees of the Blue Cross and
Blue Shield Association

Individual Health Plan Contract Change Form (For Grandfathered Plans and pre-ACA Non-Grandfathered Plans)

Instructions: Use a ballpoint pen to complete the form and follow guidelines listed below:

GUIDELINES

Complete checked section if you are using this form to:	A	B	C	D	E	F	G	I
Remove the Policyholder	✓	✓	✓	✓	✓*	✓		✓
Remove a member	✓	✓			✓*	✓		✓
Remove a member and member moving to new policy	✓	✓	✓	✓	✓*	✓		✓
Add an eligible individual or a newborn to current coverage Reinstate an eligible individual on current coverage	✓	✓		✓	✓*	✓		✓
Change to a different plan option to decrease level of benefits, e.g., increasing deductible	✓				✓	✓		✓
Change billing option	✓					✓		✓
Cancel entire policy	✓						✓	✓

*Complete if changing plan option.

NOTE: Existing benefits will remain in place unless you complete section E. Plan Changes.

A. EXISTING POLICYHOLDER INFORMATION

Existing Policyholder Name (<i>First, Middle, Last</i>)	Social Security Number/Tax Identification Number
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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.

Please check box to left of item(s) you are changing and provide complete information.

B. CONTRACT CHANGES

<input type="checkbox"/>	<p>Removing Policyholder: <input type="checkbox"/> Annual Open Enrollment Period (End date cannot be retroactive.) <input type="checkbox"/> Death <input type="checkbox"/> Medicare Eligible</p> <p><input type="checkbox"/> Active Military Duty <input type="checkbox"/> Obtain Employer Group Coverage (Please provide copy of military papers, indicating date of entry.)</p> <p>If obtaining employer group coverage: List group name _____ List carrier name _____</p> <p>List date of event: ____/____/____</p> <p>Cancellation date will be as applicable:</p> <ul style="list-style-type: none"> • During open enrollment, the first of the month following your signature date on this change form • Day after death of policyholder or through the end of the month if family policy • Date your Medicare Supplement policy becomes effective • Date you begin basic training or are called to active military service • First of the month following start of employer group coverage (or same day if coverage starts on the first of the month)
<input type="checkbox"/>	<p>Adding Eligible Individual:</p> <p><input type="checkbox"/> Adoption, placement for adoption or foster care <input type="checkbox"/> Birth <input type="checkbox"/> Marriage <input type="checkbox"/> Gained U.S. Citizenship <input type="checkbox"/> Loss of coverage due to move to Iowa <input type="checkbox"/> Court-ordered coverage <input type="checkbox"/> Involuntary loss of group coverage or employer contribution <input type="checkbox"/> Returning from military service <input type="checkbox"/> Legal guardianship <input type="checkbox"/> Involuntary loss of creditable coverage.</p> <p><input type="checkbox"/> Qualifying event not listed _____</p> <p>For loss of group or other creditable coverage, please list prior insurance company name and policy ID number:</p> <p>_____</p> <p>List date of event: ____/____/____ Your effective date will be as described in Section H: Effective Dates.</p>
<input type="checkbox"/>	<p>Removing Member:</p> <p><input type="checkbox"/> Active Military Duty Service (Please provide copy of military papers, indicating date of entry.)</p> <p><input type="checkbox"/> Completion of full-time schooling of a dependent child age 26 or older</p> <p><input type="checkbox"/> Death</p> <p><input type="checkbox"/> Dependent Child reaches age 26 and is not a full-time student or permanently disabled</p> <p><input type="checkbox"/> Divorce/Annulment/Legal Separation</p> <p><input type="checkbox"/> Marriage of a dependent child age 26 or older</p> <p><input type="checkbox"/> Spouse Obtains Employer Group Coverage</p> <p><input type="checkbox"/> Other, Specify _____</p> <p>List date of event: ____/____/____ List name(s) of member(s) removed: _____</p> <p>If removing a member without an event, your cancellation date will be the first of the month following your signature date on this change form.</p>

Existing Policyholder Name (First, Middle, Last)	Social Security #/Tax Identification Number
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C. NEW POLICYHOLDER INFORMATION

New Policyholder Name (First Middle, Last)			Social Security Number / Tax Identification Number ¹			
Mailing Address	Street	Bldg. Name/No., Apt. No.	PO Box	City	State	Zip
Provide name of county in which policyholder resides:						
Billing Address (if different from Mailing Address)	Street	Bldg. Name/No., Apt. No.	PO Box	City	State	Zip
Telephone Number ()		E-mail Address				

D. MEMBERS ADDED TO EXISTING CONTRACT OR MEMBERS MOVED TO NEW CONTRACT

<input type="checkbox"/>	Name (First, MI, Last)	Relationship	Birthdate	Social Security Number / Tax Identification Number ¹	Gender	Full-time Student?	Disabled? ²	Tobacco User?*
	Applicant	Self			<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Spouse	Spouse			<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Dependent				<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Dependent				<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

Are you, your spouse, or any dependents listed above enrolled in Medicare?
 Yes No If yes, please provide names: _____

*Answer yes if the person listed has used any form of tobacco during the 12 months immediately preceding the date of this application.

¹Social 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.

²Disabled dependents and full-time students age 26 or older must be unmarried to be eligible for coverage as a dependent.

E. PLAN CHANGES

1. Complete this section to decrease your level of benefits.
 If you have a post-Pool 4 or Pool 5 plan, you may move to a plan with lesser benefits within the same plan family at any time during the year (i.e., increasing your deductible within the same plan family). You must be a resident of Iowa to change your deductible amount.

a. Select your health plan option by placing a check mark in the box prior to plan deductible level.
 b. Select a first of the month effective date: ___/___/___ (If you do not list an effective date, your effective date will be the first of the month following signature date.)

2. If you are enrolled in any other pool and wish to make a change to your benefits, you will need to apply for an ACA (Affordable Care Act) plan during an annual open enrollment or within a special enrollment period.

Pool 5 Plan Change Options (Not Available for New Sales)

Alliance Select™ Comprehensive	Alliance Select™ Enhanced	Alliance Select™ Value	Blue PriorityHSA™	Blue Basics™	Blue Advantage Premier™	Blue Advantage HSA™	Blue Advantage Standard™
<input type="checkbox"/> 500	<input type="checkbox"/> 750	<input type="checkbox"/> 2000	<input type="checkbox"/> 1700A	<input type="checkbox"/> 3000	<input type="checkbox"/> 1500 with Blue Rx Value	<input type="checkbox"/> 1900 with Blue Rx Complete	<input type="checkbox"/> 2500 with Blue Rx Value
<input type="checkbox"/> 1000	<input type="checkbox"/> 1250	<input type="checkbox"/> 5000	<input type="checkbox"/> 1700B	<input type="checkbox"/> 5000	<input type="checkbox"/> 2500 with Blue Rx Value	<input type="checkbox"/> 3000 with Blue Rx Complete	<input type="checkbox"/> 4000 with Blue Rx Value
<input type="checkbox"/> 1500	<input type="checkbox"/> 1850		<input type="checkbox"/> 2750A		<input type="checkbox"/> Maternity (\$2500 Deductible)		<input type="checkbox"/> 2500 with Blue Rx Complete
<input type="checkbox"/> 3000	<input type="checkbox"/> 2500		<input type="checkbox"/> 2750B		<input type="checkbox"/> 1500 with Blue Rx Complete		<input type="checkbox"/> 4000 with Blue Rx Complete
<input type="checkbox"/> 4500	<input type="checkbox"/> 5500		<input type="checkbox"/> 5400A		<input type="checkbox"/> 2500 with Blue Rx Complete		
	<input type="checkbox"/> 9500		<input type="checkbox"/> Maternity (\$2500 Deductible)		<input type="checkbox"/> Maternity (\$2500 Deductible)		

If you select a Blue Advantage plan, you must complete form N-5423.

Existing Policyholder Name <i>(First, Middle, Last)</i>	Social Security #/Tax Identification Number
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E. PLAN CHANGES (CONT'D)

Pool 4 Plan Change Options (Not Available for New Sales)

Alliance SelectSM Comprehensive <input type="checkbox"/> 300 <input type="checkbox"/> 750 <input type="checkbox"/> 1250 <input type="checkbox"/> 1750	Alliance SelectSM Enhanced <input type="checkbox"/> 600 <input type="checkbox"/> 1200 <input type="checkbox"/> 1800 <input type="checkbox"/> 2400 <input type="checkbox"/> 3000 <input type="checkbox"/> 4200	Alliance SelectSM Essential <input type="checkbox"/> 1500 <input type="checkbox"/> 2500	HSA <input type="checkbox"/> 1550 <input type="checkbox"/> 2550	Classic Blue[®] <input type="checkbox"/> 3000 <input type="checkbox"/> 5000
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Contact your agent or call the Customer Service number on your ID card if you need to verify which plan you currently have.

Please indicate "Yes" or "No" for each of the following Wellmark optional benefits. If you do not answer "Yes" or "No" for each optional benefit, Wellmark will assign optional benefits as covered in existing policy.

Blue Dental Yes No **Supplemental Accident** Yes No *(Not available with HSA products)*

Contraceptives Yes No *(Available with grandfathered plans only. Contraceptive coverage included with non-grandfathered plans.)*

Important information is 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.

F. BILLING INFORMATION - Complete if new policyholder, changing billing option or selecting "Use Billing information on file with Wellmark".

1a. 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

1b. 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 deductions available to self-employed persons? Yes No

If you answered "yes" to either 1a or 1b, 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)

2. How do you want to pay for health premiums? Please do not send payment with this form.

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

a. Direct Bill. On what basis? Semi-annually Annually

b. Use billing information on file with Wellmark. *(Available only for those with current Wellmark individual coverage.)*

c. Automatic Account Withdrawal from Policyholder's account.

d. Automatic Account Withdrawal from account other than Policyholder's.

If you checked c or d, please complete the following:

On what basis? Monthly Quarterly Semi-annually Annually

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

From: Checking Savings

Attach a voided check OR complete the following information:

Financial Institution Name: _____

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

Financial Institution Routing Number (9 digits): _____

Account Number: _____

State Code (found on your check on top right corner above the date - e.g., 78): _____

If Direct Bill is **not** selected:

I hereby certify that I have read and understand the section below entitled "Authorization and Certification," and agree to the terms regarding automatic premium withdrawals as described therein. As the Bank Account Holder, I authorize Wellmark to make automatic withdrawals from the account shown in the amount of the premium and fees. I understand and agree that notices of any premium and fee adjustments provided to the Policyholder shall constitute notice to the undersigned of any such adjustment. This authorization supersedes and replaces any previous authorization given by me for automatic premium withdrawal.

Bank Account Holder's Signature (if other than Policyholder) _____ **Date** ____/____/____

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.

Existing Policyholder Name (First, Middle, Last)	Social Security #/Tax Identification Number
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G. CANCELLATION OF ENTIRE POLICY

I am requesting cancellation of my entire policy effective ____/ 1 / _____. I understand Wellmark does not allow cancellation on odd dates, and the earliest available cancellation date is the 1st day of the month after Wellmark's receipt of this request. My coverage will continue through the last day of the month in which I notify Wellmark to cancel. If I have vision and/or dental benefits for any member under age 19 included in my health coverage, these vision and/or dental benefits will be canceled with my health coverage. To cancel automatic account withdrawal, Wellmark must receive this request by the 10th of the month prior to my next scheduled withdrawal. To otherwise stop payment, I will notify my bank. I will be responsible for any associated fees from my bank.

H. EFFECTIVE DATES

When adding eligible individuals to existing coverage, effective dates will be:

Event:	Effective Date:
Birth	Date of birth
Adoption, placement for adoption or foster care	Date of adoption, placement for adoption or foster care
Appointment as a Legal Guardian	Date of event
Court-ordered Coverage	Date of event
Marriage	First day of the month following the event
Returning from Military Service	Date of discharge or inactive status from the military service or termination of military health coverage or the first of the following month
Gained U.S.A. Citizenship	First of the month following the event
Involuntary loss of creditable coverage*	First of the month following the event

*Involuntary loss of creditable coverage includes:

- | | |
|---|---|
| <ul style="list-style-type: none"> • Exhaustion of COBRA • Death of Policyholder / Certificate Holder • Policyholder / Certificate Holder enrolls in Medicare • No longer a dependent • Permanent move to Iowa | <ul style="list-style-type: none"> • Termination of employment / reduction in hours • Divorce / Dissolution of Domestic Partnership • Loss of <i>hawk-i</i> eligibility • Loss of minimum essential coverage • Loss of group coverage or loss of employer contribution to group coverage |
|---|---|

I. AUTHORIZATION, CERTIFICATION AND SIGNATURE

I certify that I have carefully and fully read the Authorization and Certification language appearing below.

I certify that I am legally authorized to make changes in coverage for myself and on behalf of all other persons named on my current policy and in this form, and I further have confirmed with all persons named on my current policy and on this form that my signature is binding to change coverage. If I have made changes in my plan selection, I understand that I am applying for the Health Plan Options indicated on this form which are underwritten 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 form and the appropriate premium and service fee payment amount, if applicable, are received and accepted by Wellmark.

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 form, each person to be covered on one of these Health Plan Options must maintain his/her residency in an Iowa county other than Allamakee, Fayette, or Winneshiek. 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 form are full, true, and correct. I have consulted with each other person named in this form to confirm that information about him/her 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 form 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 form, Wellmark will be entitled to declare coverage applied for void and to refuse allowance of benefits to any person thereunder.

Special Enrollment Notification Period

For special enrollment events, Wellmark must be notified within 60 days of the event (or 120 days of returning from military service). Please see Section H for effective date information.

Tobacco User Status

If I answered "No" to the tobacco user question for any person listed in Section D, 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 will start applying the tobacco user rate on the first of the month following Wellmark's receipt of this information.

Existing Policyholder Name (First, Middle, Last)

Social Security #/Tax Identification Number

I. AUTHORIZATION, CERTIFICATION AND SIGNATURE (CONT'D)

Dental Exclusion Periods

In the event I am adding Blue Dental coverage 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 will not be waived or reduced even if I or any other person named in this form have qualifying existing coverage or qualifying previous coverage.

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.

Providing Social Security Numbers or Tax Identification Numbers

In order for Wellmark to report my coverage status to the federal government, I understand I must provide to Wellmark my Social Security number or tax identification number and the Social Security numbers or tax identification numbers of all members covered under my 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, I understand that Wellmark will be unable to report and send the information needed to complete federal tax returns. If I have not previously provided the Social Security numbers or tax identification numbers to Wellmark for all members covered under my coverage, I will contact Wellmark by calling the Customer Service number on my ID card. I understand if I do not provide the Social Security numbers or taxpayer identification numbers to Wellmark for this purpose, I may be subject to a \$50 penalty per violation imposed by the Internal Revenue Service.

Health Care Reform Mandates

If I currently have a grandfathered health plan, I understand that making a change to my current benefits could potentially change the grandfathered status of my health care plan. If I lose the grandfathered status of my health care plan, I may be required to move to an ACA health plan. If I currently have a pre-ACA non-grandfathered plan, I understand that making a change to my current benefits may require I move to an ACA health plan.

Payment Arrangements

I understand and agree that the amount of my periodic premium payment and fee, if applicable, 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 fee, if applicable. These changes may occur at times other than at annual or other policy renewal.

I further understand and agree that, if I have elected to authorize automatic premium withdrawals from a deposit account, the automatic withdrawal will change periodically to correspond with the applicable premium and fee. My authorization for automatic premium 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.

Coverage Renewability

I understand that coverage is automatically renewed by payment of my premium and applicable 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.

I understand that Wellmark may terminate my policy if:

- I fail to pay my premium and service fee 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.

Existing Policyholder Name (First, Middle, Last)

Social Security #/Tax Identification Number

I. AUTHORIZATION, CERTIFICATION AND SIGNATURE (CONT'D)

ACKNOWLEDGEMENT

I have read and understand the Authorization and Certification language and hereby confirm the authority of Wellmark to make automatic withdrawals from my deposit account as described therein. This authorization supersedes and replaces any previous authorizations given by me for automatic premium withdrawal.

I certify that each person covered on a Wellmark Health Plan of Iowa, Inc. plan option is a resident of an Iowa county other than Allamakee, Fayette, or Winneshiek.

Existing Policyholder Signature X _____

Date ____/____/____

New Policyholder Signature X _____

Date ____/____/____

If applicant is a minor, please sign below.

Parent/Legal Guardian Printed Name _____

Parent/Legal Guardian Signature X _____

Date ____/____/____

If child(ren) only policy, list parent's (s')/legal guardian's (s') name(s) _____

Agent Signature, if applicable X _____

Agent No.

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This completed contract change form (pages 1 through 6) must be signed within the annual open enrollment period or within a special enrollment period. If this form is received later than 15 days after your signature date, eligibility for requested coverage and effective date are subject to change.

Send completed form to:
Wellmark Blue Cross and Blue Shield of Iowa
Mail Station 3W190
PO Box 14527
Des Moines, IA 50306-3527

OR
Fax to: 515-376-9045

OR
E-mail to: INDMEMMAIN@wellmark.com