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

Independent Licensees of the Blue Cross and Blue Shield Association

BlueDental

Group Employee Application for Health, Dental & Vision/Hearing Insurance (1-50)

Employer Information

Employer _____ Phone (_____) _____

Group Number _____

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

Address Line 2 (PO Box, Street Address) _____

City _____ State _____ Zip Code _____

Employee Classification (if applicable) _____

A. Employee Information

First Name _____ MI _____ Last Name _____

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

Address Line 2 (PO Box, Street Address) _____

City _____ State _____ Zip Code _____

County _____

Home Phone Number (_____) _____ - _____ Work Phone Number (_____) _____ - _____ Ext. _____

Email address (optional) _____

Date of Birth _____/_____/_____ (mm/dd/yyyy) Social Security Number/Tax Identification Number _____-_____-_____
(Social Security Number (SSN) or Tax Identification Number (TIN) must be provided for you and every covered member.)

Gender ☐ M ☐ F

Status ☐ Married ☐ Single ☐ Divorced ☐ Legally Separated ☐ Common Law
☐ Domestic Partner (Domestic Partnership Certification required)

Date of Hire (required) _____/_____/_____ (mm/dd/yyyy)

Employment Status ☐ Active ☐ COBRA ☐ Retired ☐ Seasonal

Job Title (optional) _____ Hours Worked/Week _____

Waiver of Coverage - Complete only if you do not want coverage.

I decline coverage for:

☐ Medical ☐ Dental ☐ Vision/Hearing

(Note: If you decline medical coverage, you must also decline vision/hearing coverage.)

I am declining medical coverage due to existence of another coverage:

☐ Spouse's or Domestic Partner's Employer's Plan ☐ Medicare ☐ COBRA from prior employer ☐ VA Eligibility
☐ Individual Plan ☐ Tri-Care ☐ Medicaid ☐ I (we) do not have other coverage at this time.
☐ Other _____

I understand that by waiving coverage at this time, I will not be allowed to participate unless I experience a special enrollment event or at the next open enrollment period. I have read Section G within this application.

Employee First Name _____ Employee Last Name _____

Social Security Number _____ Employee Signature _____

B. Enrollment Reason or Event

Enrollment Reason: ☐ Open Enrollment ☐ Newly Eligible ☐ Special Enrollment (If you check this option, complete the following)

Special Enrollment Event Reason:

☐ Birth/Adoption or Placement for Adoption
☐ Marriage
☐ Divorce
☐ Foster Child Placement
☐ Legal guardianship
☐ Access to a qualified health plan due to a permanent move to Iowa
☐ Court-ordered coverage
☐ Involuntary loss of creditable coverage
☐ Returning from military service
☐ Other: _____

List date of special enrollment event _____/_____/_____ (mm/dd/yyyy)

C. Dependent Information

If you need to list more than four dependents, please write all necessary information on a separate sheet of paper and attach to this application.

Name (First, MI, Last)		Date of Birth (mm/dd/yyyy)	Social Security Number/ Tax Identification Number[1]	Gender	FT Student?[2]	Disabled?[2]
☐ Spouse ☐ Domestic Partner		_____/_____/_____		☐ Male ☐ Female	N/A	N/A
☐ Child		_____/_____/_____		☐ Male ☐ Female	☐ Yes ☐ No	☐ Yes ☐ No
☐ Child		_____/_____/_____		☐ Male ☐ Female	☐ Yes ☐ No	☐ Yes ☐ No
☐ Child		_____/_____/_____		☐ Male ☐ Female	☐ Yes ☐ No	☐ Yes ☐ No
☐ Child		_____/_____/_____		☐ Male ☐ Female	☐ Yes ☐ No	☐ Yes ☐ No

[1]Social Security Number (SSN) or Tax Identification Number (TIN) must be provided for every covered member.

[2]Dependent(s) age 26 or older must be unmarried and either a full-time student or a disabled dependent (disability information requested in Section E).

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: _____

2. ☐ Yes ☐ No Are you a court appointed legal guardian and/or have power of attorney for anyone listed above?
   If yes, list first and last name of that person _____
   What is your relationship to that person? _____
   If your address is different than the name of that person, please provide that person's address:
   Address Line 1 (Street Address or Apt/Suite#) _____
   Address Line 2 (PO Box, Street Address) _____
   City _____ State _____ Zip Code _____

Note: If applicable, please provide the legal documentation for the dependent child(ren) to meet the eligibility requirements for enrollment.

3. ☐ Yes ☐ No Does your spouse or domestic partner or any of the dependent(s) listed above have an address different than the address listed in Section A. If yes and not already provided above, please complete following:
   Spouse/Domestic Partner/Dependent Name _____
   Address Line 1 (Street Address or Apt/Suite#) _____
   Address Line 2 (PO Box, Street Address) _____
   City _____ State _____ Zip Code _____

D. Coverage Selected

Mark each box for products you are selecting and indicate the plan name. Then, indicate who should have coverage for each product.

1. ☐ Health List health plan name: _____
   - ☐ Employee
   - ☐ Employee + Spouse/Domestic Partner
   - ☐ Employee + Child(ren)
   - ☐ Employee + Spouse/Domestic Partner + Child(ren)

2. Vision/Hearing may only be selected if you have selected a health plan:
   ☐ Vision/Hearing[1]
   - ☐ Employee
   - ☐ Employee + Spouse/Domestic Partner
   - ☐ Employee + Child(ren)
   - ☐ Employee + Spouse/Domestic Partner + Child(ren)

   Pediatric vision coverage for children age 18 and under is included in your Wellmark health plan. Pediatric vision coverage will discontinue at the end of the month the child turns age 19.

3. ☐ Dental[2] List dental plan name: _____
   - ☐ Employee
   - ☐ Employee + Spouse/Domestic Partner
   - ☐ Employee + Child(ren)
   - ☐ Employee + Spouse/Domestic Partner + Child(ren)

[1]The vision plan is provided by Avesis Vision and the hearing discount savings plan is provided by EPIC Hearing Healthcare. Avesis Vision and EPIC Hearing Healthcare are independent companies that do not provide Wellmark Blue Cross and Blue Shield products or services. Avesis Vision is underwritten by Fidelity Security Life Insurance Company, Kansas City, Missouri.

[2]This policy does not include pediatric dental coverage. Pediatric dental coverage is available in the insurance market and can be purchased as a stand alone product. Please contact your agent or visit Iowa's Marketplace if you wish to purchase stand alone pediatric dental coverage or a stand alone dental product.

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 800-847-1506.

E. Other Coverage

Medicare Coverage

☐ Yes ☐ No Are you or anyone listed in the Dependent Information section Social Security disabled?

If yes, list names _____

☐ Yes ☐ No Are you and/or anyone listed in the Dependent Information section enrolled in Medicare?

If yes, complete following as appropriate:

Employee 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): _____/_____/_____

Concurrent Coverage

☐ Yes ☐ No Will you, your spouse or domestic partner, or your dependent(s) keep other coverage in addition to this coverage?

If yes, list name(s) of applicants keeping other coverage _____

Provide complete information below:

Other Insurance Carrier Name _____

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

Address Line 2 (PO Box, Street Address) _____

City _____ State _____ Zip Code _____

Concurrent Coverage, cont'd.

Other Coverage Effective Date _____/_____/_____ Other Coverage End Date _____/_____/_____

If the other coverage is another BCBS carrier in another state, indicate carrier name and state _____

Policyholder Name _____ Policyholder Birthdate _____/_____/_____

List dependent(s) covered under policy _____

List name of person that has primary responsibility for the dependent(s)_____

☐ Yes ☐ No Is there a court ordered document?

F. Primary Care Provider Information (complete only if your benefit plan requires enrollee to select PCP)

For each person named in section A, complete following information

Employee

Provider Name _____

Provider ID _____

☐ Yes ☐ No Are you an established patient?

OB/GYN Provider Name (not required) _____

OB/GYN Provider ID (not required) _____

☐ Yes ☐ No Are you an established patient?

Spouse or Domestic Partner

Provider Name _____

Provider ID _____

☐ Yes ☐ No Are you an established patient?

OB/GYN Provider Name (not required) _____

OB/GYN Provider ID (not required) _____

☐ Yes ☐ No Are you an established patient?

Dependent 1

Provider Name _____

Provider ID _____

☐ Yes ☐ No Are you an established patient?

OB/GYN Provider Name (not required) _____

OB/GYN Provider ID (not required) _____

☐ Yes ☐ No Are you an established patient?

Dependent 2

Provider Name _____

Provider ID _____

☐ Yes ☐ No Are you an established patient?

OB/GYN Provider Name (not required) _____

OB/GYN Provider ID (not required) _____

☐ Yes ☐ No Are you an established patient?

Dependent 3

Provider Name _____

Provider ID _____

☐ Yes ☐ No Are you an established patient?

OB/GYN Provider Name (not required) _____

OB/GYN Provider ID (not required) _____

☐ Yes ☐ No Are you an established patient?

Dependent 4

Provider Name _____

Provider ID _____

☐ Yes ☐ No Are you an established patient?

OB/GYN Provider Name (not required) _____

OB/GYN Provider ID (not required) _____

☐ Yes ☐ No Are you an established patient?

G. Important Information Regarding Waiver of Enrollment

If you are declining enrollment for yourself or your dependent(s) (including your spouse or domestic partner), you may be able to enroll yourself or your dependent(s) in this plan if you notify us within 60 days of one of the following events:

- Birth, adoption, placement for adoption or foster child placement
- Court-ordered coverage
- Involuntary loss of creditable coverage
- Legal guardianship
- Access to a qualified health plan due to a permanent move to Iowa

Additionally, you may be able to enroll yourself or one of your dependent(s) following return from military service if you notify us within 120 days. To request special enrollment or obtain more information, contact Customer Service, Wellmark, Inc., PO Box 9232, Station 3E499, Des Moines, IA 50306-9232, or call 800-524-9242.

H. Authorization and Certification

I certify that I am legally authorized to apply for coverage for myself and all other persons named in this application. I understand that I am making application for the coverage sponsored by my employer or group sponsor offered by Wellmark, Inc., doing business as Wellmark Blue Cross and Blue Shield of Iowa, or Wellmark Health Plan of Iowa, Inc. (each referenced herein as "Wellmark") and, when applicable, vision insurance provided by the vision insurance carrier (collectively the "Insurers"). I authorize my employer, as my agent, to deduct from my pay or collect from me in advance the monthly rates therefore and remit such sums to the Insurers on my behalf. This authorization is to remain in effect until the Insurers are notified by me or my employer to the contrary. I understand that written notice of rate changes will be furnished to my employer as my agent. I further understand that the coverages applied for will not start until after this application and the appropriate coverage rates are received and accepted by each Insurer and an effective date of coverage is established by the Insurers.

H. Authorization and Certification, cont'd.

I certify that, after this application was completed, I carefully and fully read it, that the statements and answers set forth are full, true, and correct to the best of my knowledge and belief, and that no information required to be given, either expressly or by implication, has been knowingly withheld. I understand that the Insurers will rely on the completeness and truthfulness of the information given and the statements made, and that if I have made any false statements or misrepresentations, or have failed to disclose or concealed any material fact, the Insurers will be entitled to declare the contracts applied for void and to refuse allowance on benefits to any person thereunder.

I acknowledge I have received or have been advised and understand I will receive from my employer the Summary of Benefits and Coverage (SBC).

The coverage effective date will be assigned according to Wellmark guidelines. For special enrollment events, Wellmark must be notified within 60 days of event (or 120 days of returning from military service). The coverage effective dates for special enrollment events will be the 1st of 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.

In the event I have selected a High Deductible Health Plan, I understand that enrolling in such coverage does not guarantee that I am or will be eligible to make contributions to an HSA or that contributions can be made to an HSA on my behalf.

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 number or taxpayer identification numbers to Wellmark for this purpose, you will be subject to a $50 penalty per violation imposed by the Internal Revenue Service.

I authorize any health care provider, including but not limited to; surgeon, physician, psychologist, nurse, social worker, or health care facility to release to the Insurers all health and mental health records, including those 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 dependent(s) eligible for health care 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 the Insurers or 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 healthcare 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 the Insurers then have the right to condition eligibility determination and enrollment on the receipt of this signed authorization.

I have read and understand the Authorization and Certification language on this application and acknowledge receipt of a fully completed copy 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 handwritten signature.

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

Print Name _____

Your Signature X_____ **Date Signed** _____/_____/_____