Wellmark

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

Independent Licensees of the Blue Cross and Blue Shield Association

BlueDental℠

BlueDental PPO℠

Clear Form

Failure to fill out this application completely may result in a delay of coverage.

Group Application For Health & Dental Insurance

☐ New Hire ☐ Late Enrollee ☐ Special Enrollee ☐ Change

This area completed by Employer:

Group/Billing Unit No.: _____ Department No.: _____ Effective Date: ____/____/____

Employer Name: _____

Address Line 1 (Street Address or Suite#): _____

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

City: _____ State: _____ ZIP Code: _____

A. Employee Information

Name (First, MI, Last): _____

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

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

City: _____ State: _____ ZIP Code: _____

Telephone: (_____) _____

E-mail Address (optional): _____

Employment Status: ☐ Full-Time ☐ Part-Time ☐ Retiree ☐ COBRA

Hire Date: _____/_____/_____

☐ Male ☐ Female

Birthdate:_____/_____/_____

Status: ☐ Single ☐ Married
☐ Common Law (Notarized Affidavit Required)
☐ Domestic Partner (Notarized Affidavit Required)

Social Security Number/Tax Identification Number[1]: _____

Health: ☐ Self ☐ Spouse or Domestic Partner ☐ Child(ren) **Health Plan Code**_____ **Deductible Amount** _____

Dental: ☐ Self ☐ Spouse or Domestic Partner ☐ Child(ren)

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.

B. Event(s) or Reason(s) for Changing Contract

☐ Marriage ☐ Death ☐ Divorce ☐ Birth/Adoption ☐ Involuntary Loss of Eligibility for Creditable Coverage

☐ Other, Specify: _____ Date of Event: ____/____/____

C. Members Covered (Please indicate who you are choosing to cover.)

List Name (First, Last) of all others to be covered	Birthdate	Social Security Number/ Tax Identification Number[1]	Gender	Full-Time Student?	Disabled?
Spouse or Domestic Partner	/ /		☐ M ☐ F		☐ Yes
Dependent	/ /		☐ M ☐ F	☐ Yes	☐ Yes
Dependent	/ /		☐ M ☐ F	☐ Yes	☐ Yes
Dependent	/ /		☐ M ☐ F	☐ Yes	☐ Yes

[1]A Social Security Number (SSN) or Tax Identification Number (TIN) is required for you and every covered member. Please provide your SSN or TIN for timely processing. Further review may be necessary if an SSN or TIN is not provided.

Employee Name (First, Last)	Social Security Number

D. Medicare Coverage (Required.)

☐ Yes ☐ No Are you and/or anyone listed in section C Social Security disabled?
If yes, list names _____
☐ Yes ☐ No Are you and/or anyone listed in section C 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): _____/_____/_____

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

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

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

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

E. Other Carrier Information (Required.)

☐ Yes ☐ No Will you, your spouse or domestic partner, or your dependents keep other health coverage in addition to this Wellmark, Inc. coverage?

If yes, please complete the following:

Policyholder Name (First, Last): _____ Date of Birth: _____/_____/_____

Please list those covered by other health plan(s):_____

Policy No.: _____ Effective Date: _____/_____/_____

Employer Name (if coverage is through employer group):_____

Insurance Company/HMO Name: _____

Address Line 1 (Street Address or Suite#): _____

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

City: _____ State: _____ ZIP Code: _____

Phone Number (if known): (_____) _____

☐ Yes ☐ No Is there a divorce decree/court order that requires one parent to provide health insurance coverage for any dependent? If yes, please complete the following:

List dependent(s): _____

List name of person required to provide health insurance: _____

List name of person who has primary physical custody: _____

F. Waiver of Enrollment (Please complete if you are waiving health or dental benefits.)

☐ I waive health coverage for my dependents and myself. Please indicate one of the following reasons:
- ☐ I (We) have coverage under another health care benefit plan.
- ☐ I (We) do not wish to enroll in the health plan.

☐ I waive dental coverage for my dependents and myself. Please indicate one of the following reasons:
- ☐ I (We) have coverage under another dental plan.
- ☐ I (We) do not wish to enroll in the dental plan.

Please see the Important Information Regarding Waiver of Enrollment section below.

Employee Name (First, Last)	Social Security Number

G. Important Information Regarding Waiver of Enrollment

If you are declining enrollment for yourself or your dependents (including your spouse or domestic partner) because of other health insurance or group health plan coverage, you may be able to enroll yourself or your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 31 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage). In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 31 days (or within 60 days of birth, adoption or placement for adoption for fully insured and self-funded non-ERISA groups) after the marriage, birth, adoption or placement for adoption. Additionally, you must enroll within 60 days after you lose eligibility for coverage under Medicaid or CHIP or become eligible for Medicaid or CHIP premium assistance. 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"). 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 Wellmark on my behalf. This authorization is to remain in effect until Wellmark is 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 Wellmark and an effective date of coverage is established by Wellmark.

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 Wellmark 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, Wellmark 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).

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 infromation 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.

HSA Coverage

If the Health Plan Deductible that I have selected is combined with a Health Savings Account (HSA), I understand that enrolling in HSA 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.

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, 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 dependents 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 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.

Employee Name (First, Last)	Social Security Number

H. Authorization and Certification (cont'd.)

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.

I have read and understand the Important Information Regarding Waiver of Enrollment and Authorization and Certification language on this application and acknowledge receipt of a fully completed copy of this application.

Employee Signature_____ **Date**_____/_____/_____