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 ACA plans effective 1/1/2016 and after)

Instructions
- Please use a ballpoint pen to complete the required information as indicated in Section A.
- If the policyholder is under age 18, the signature and relationship of a parent or legal guardian is required. Please provide proof of guardianship. If this form is for children only, the policyholder must be the youngest child.
- This completed contract change form (pages 1 through 9) 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.

A. TYPE OF CHANGE (MARK ALL THAT APPLY)

		B	C	D	E	F	G	H	I	K
☐	Remove the Policyholder	✓	✓	✓	✓	✓*	✓*		✓	✓
☐	Remove a member from entire policy	✓	✓			✓*	✓*			✓
☐	Remove a member and member moving to new policy	✓	✓	✓	✓	✓*	✓*		✓	✓
☐	Add an eligible individual or a newborn	✓	✓	✓		✓*	✓*			✓
☐	Reinstate an eligible individual on current coverage	✓	✓	✓		✓*	✓*			✓
☐	Add an eligible individual to dental or vision	✓		✓			✓			✓
☐	Change to a different plan option	✓				✓	✓			✓
☐	Change billing option	✓							✓	✓
☐	Cancel entire policy	✓						✓		✓
☐	Cancel health coverage only — keep dental	✓						✓		✓
☐	Cancel dental or vision	✓						✓		✓

*Complete if changing plan option.
NOTE: Existing benefits and billing information will remain in place unless you complete all appropriate sections.

B. EXISTING POLICYHOLDER INFORMATION (PLEASE LIST ON TOP OF EACH PAGE)

Existing Policyholder Name *(First, Middle, Last)*	Wellmark Policyholder Member Identification (ID) Number

If Wellmark ID is not available, please provide your Social Security Number (SSN) or Tax Identification Number (TIN).

C. ADDING OR REMOVING POLICYHOLDER, SPOUSE AND/OR DEPENDENTS

☐ **Removing Policyholder:** ☐ Annual Open Enrollment Period (End date cannot be retroactive.) ☐ Death ☐ Medicare Eligible ☐ Active Military Service ☐ Obtain Employer Group Coverage

If obtaining employer group coverage: List group name ______________________ List carrier name ______________________

List date of event: ______/_______/______

Cancellation date will be as applicable:
- During open enrollment, in accordance with federal guidelines
- 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)

☐ **Annual Open Enrollment Period**
Your effective date will be assigned in accordance to federal guidelines. For further information, please call Customer Service using the phone number on the back of your ID card or contact your authorized agent.

☐ **Adding Eligible Individual:**
☐ Birth ☐ Adoption, placement for adoption or foster child placement ☐ Marriage/Common Law ☐ Domestic partnership ☐ Permanent move to Iowa ☐ Court-ordered coverage ☐ Legal guardianship (please provide copy of legal guardianship document) ☐ Involuntary loss of employer coverage or employer contribution ☐ Employer renewal date is outside of the annual open enrollment period for an Individual Health Plan ☐ Returning from military service ☐ Involuntary loss of creditable coverage ☐ Qualifying event not listed ______________________

For loss of employer group or other creditable coverage, please list prior insurance company name and ID number below:

____

List date of event: _____/_____/_____

Your effective date will be as described in Section J: Effective Dates.

Existing Policyholder Name *(First, Middle, Last)*	Wellmark Policyholder Member Identification (ID) Number

C. ADDING OR REMOVING POLICYHOLDER, SPOUSE AND/OR DEPENDENTS, cont'd

☐ **Removing Member:**
☐ Active Military Duty Service (Please provide copy of military papers, indicating date of entry.) ☐ Completion of full-time schooling of a dependent child age 26 or older ☐ Death ☐ Dependent Child reaches age 26 and is not a full-time student or permanently disabled ☐ Divorce/Annulment/Legal Separation/Dissolution of domestic partnership ☐ Marriage of a dependent child age 26 or older ☐ Spouse Obtains Employer Group Coverage ☐ Other, Specify ____

List date of event: _______/_______/______ **List name(s) of member(s) removed:** ______________________________

If removing a member without an event, your cancellation date will be the last day of the month in which you sign the change form. If signing on the last day of the month, your cancellation date will be that same date. (For example, signing on Dec. 31 results in a same-day cancellation date of Dec. 31.)

D. MEMBERS TO BE COVERED

List persons to be covered & their relationship to policyholder **Name (First, MI, Last)**	Relationship	Birthdate	Social Security Number/ Tax Identification Number[1]	Gender	Full-time Student?[2]	Disabled?[2]	Enrolled in Medicare?	Tobacco User?[4]
Policyholder	Self		a. SSN/TIN ________ b. ☐ Does not have an SSN/TIN c. ☐ I refuse to provide the SSN/TIN	☐ M ☐ F	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Spouse or Domestic Partner	Spouse or Domestic Partner[3]		a. SSN/TIN ________ b. ☐ Does not have an SSN/TIN c. ☐ I refuse to provide the SSN/TIN	☐ M ☐ F	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Dependent 1			a. SSN/TIN ________ b. ☐ Does not have an SSN/TIN c. ☐ I refuse to provide the SSN/TIN	☐ M ☐ F	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Dependent 2			a. SSN/TIN ________ b. ☐ Does not have an SSN/TIN c. ☐ I refuse to provide the SSN/TIN	☐ M ☐ F	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Dependent 3			a. SSN/TIN ________ b. ☐ Does not have an SSN/TIN c. ☐ I refuse to provide the SSN/TIN	☐ M ☐ F	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Dependent 4			a. SSN/TIN ________ b. ☐ Does not have an SSN/TIN c. ☐ I refuse to provide the SSN/TIN	☐ M ☐ F	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

[1]The IRS requires Wellmark to collect SSNs/TINs for federal reporting purposes. Wellmark will follow up with you to collect this information if you do not check/complete a., b., or c. for each person listed. Failure to provide the SSN/TIN information may result in a $50 penalty, per violation, assessed to you by the IRS.
[2]Disabled dependents and full-time students age 26 or older must be unmarried to be eligible for coverage as a dependent.
[3]Domestic Partnership Certification required.
[4]Answer yes if the person age 18 or older listed has used any form of tobacco, with the exception of religious or ceremonial purposes, on average of four or more times per week within the past six months.

E. POLICYHOLDER ADDRESS/PHONE NUMBER

Physical Address Line 1 (Street Address or Apt./Suite #)	Telephone Number ( )	
Address Line 2 (PO Box, Street Address)		
City	State	Zip
Mailing Address Line 1 - if different from Physical Address (Street Address or Apt./Suite #)	County in which policyholder resides	
Address Line 2 (PO Box, Street Address)		
City	State	Zip
Email Address		

Existing Policyholder Name *(First, Middle, Last)*	Wellmark Policyholder Member Identification (ID) Number

F. PLAN CHANGES

Complete this section to update your plan. You must be a resident of Iowa to change your plan.

1. You may change your plan at the time of a qualifying Special Enrollment Period (SEP) event or at open enrollment.
2. You may add or cancel Blue Dental and/or Avesis vision coverage at any time. To add vision coverage, you must also have a health plan.

Current Plan Options Available for New Sales for effective dates 1/1/2016 and after

Select your new plan option by placing a check mark in the box prior to the plan.

The following are underwritten by Wellmark Blue Cross and Blue Shield of Iowa:				The following are underwritten by Wellmark Health Plan of Iowa, Inc.:				
Health Plan Options				**Health Plan Options**				
SimplyBlue℠	**CompleteBlue℠**	**EnhancedBlue℠**	**myBlue HSA℠**	**SimplyBlue℠**	**CompleteBlue℠**	**EnhancedBlue℠**	**myBlue HSA℠**	**Blue Rewards℠**
☐ 5000 PPO	☐ 2500 PPO ☐ 3000 B PPO ☐ 4000 PPO ☐ Max 5000 PPO	☐ 500 PPO ☐ 1250 PPO ☐ Max 2750 B PPO	☐ 2000 PPO ☐ 3350 PPO ☐ 5950 PPO	☐ 5000 HMO	☐ 2500 HMO ☐ 3000 A HMO ☐ 4000 HMO ☐ Max 5000 HMO	☐ 500 HMO ☐ 1250 HMO ☐ Max 2750 A HMO	☐ 2000 HMO ☐ 3350 HMO ☐ 5950 HMO	☐ 1000 ☐ 1500 ☐ 5500

If I have elected an HMO plan — SimplyBlue, CompleteBlue, EnhancedBlue, or myBlue HSA — I certify that the policyholder named on this form is a resident of an Iowa county other than Allamakee, Fayette, or Winneshiek. If I have elected a Blue Rewards plan, I certify that the policyholder named on this form is a resident of a county in which the plan selected is offered. [To verify that Blue Rewards is available in your county, visit Wellmark.com/BlueRewards or contact an agent.] ☐ Yes

MY PERSONAL DOCTOR SELECTION: Please list a Personal Doctor for each person to be covered. This information is required for all health plan selections. You may also see a Personal Doctor referred to as a Primary Care Physician (PCP) in other Wellmark documentation.

Policyholder

Doctor Name: ______

Doctor Address Line 1 (Street Address or Apt/Suite#): ______

Doctor Address Line 2 (PO Box, Street Address): ______

City: ______ State: ______ ZIP: ______

☐ Yes ☐ No Are you an established patient?

OB/GYN Name (optional): ______

OB/GYN Address Line 1 (Street Address or Apt/Suite#): ______

OB/GYN Address Line 2 (PO Box, Street Address): ______

City: ______ State: ______ ZIP: ______

☐ Yes ☐ No Are you an established patient?

Spouse or Domestic Partner

Doctor Name: ______

Doctor Address Line 1 (Street Address or Apt/Suite#): ______

Doctor Address Line 2 (PO Box, Street Address): ______

City: ______ State: ______ ZIP: ______

☐ Yes ☐ No Are you an established patient?

OB/GYN Name (optional): ______

OB/GYN Address Line 1 (Street Address or Apt/Suite#): ______

OB/GYN Address Line 2 (PO Box, Street Address): ______

City: ______ State: ______ ZIP: ______

☐ Yes ☐ No Are you an established patient?

Existing Policyholder Name *(First, Middle, Last)*	Wellmark Policyholder Member Identification (ID) Number

MY PERSONAL DOCTOR SELECTION, cont'd: Please list a Personal Doctor for each person to be covered. This information is required for all health plan selections. You may also see a Personal Doctor referred to as a Primary Care Physician (PCP) in other Wellmark documentation.

Dependent 1

Doctor Name: ______________________________

Doctor Address Line 1 (Street Address or Apt/Suite#): ______________________________

Doctor Address Line 2 (PO Box, Street Address): ______________________________

City:______________________________ State:______________ ZIP:__________

☐ Yes ☐ No Are you an established patient?

OB/GYN Name (optional):______________________________

OB/GYN Address Line 1 (Street Address or Apt/Suite#): ______________________________

OB/GYN Address Line 2 (PO Box, Street Address): ______________________________

City:______________________________ State:______________ ZIP:__________

☐ Yes ☐ No Are you an established patient?

Dependent 2

Doctor Name: ______________________________

Doctor Address Line 1 (Street Address or Apt/Suite#): ______________________________

Doctor Address Line 2 (PO Box, Street Address): ______________________________

City:______________________________ State:______________ ZIP:__________

☐ Yes ☐ No Are you an established patient?

OB/GYN Name (optional):______________________________

OB/GYN Address Line 1 (Street Address or Apt/Suite#): ______________________________

OB/GYN Address Line 2 (PO Box, Street Address): ______________________________

City:______________________________ State:______________ ZIP:__________

☐ Yes ☐ No Are you an established patient?

Dependent 3

Doctor Name: ______________________________

Doctor Address Line 1 (Street Address or Apt/Suite#): ______________________________

Doctor Address Line 2 (PO Box, Street Address): ______________________________

City:______________________________ State:______________ ZIP:__________

☐ Yes ☐ No Are you an established patient?

OB/GYN Name (optional):______________________________

OB/GYN Address Line 1 (Street Address or Apt/Suite#): ______________________________

OB/GYN Address Line 2 (PO Box, Street Address): ______________________________

City:______________________________ State:______________ ZIP:__________

☐ Yes ☐ No Are you an established patient?

Existing Policyholder Name *(First, Middle, Last)*	Wellmark Policyholder Member Identification (ID) Number

MY PERSONAL DOCTOR SELECTION, cont'd: Please list a Personal Doctor for each person to be covered. This information is required for all health plan selections. You may also see a Personal Doctor referred to as a Primary Care Physician (PCP) in other Wellmark documentation.

Dependent 4

Doctor Name: ____________________

Doctor Address Line 1 (Street Address or Apt/Suite#): ____________________

Doctor Address Line 2 (PO Box, Street Address): ____________________

City:____________________ State:__________ ZIP:__________

☐ Yes ☐ No Are you an established patient?

OB/GYN Name (optional):____________________

OB/GYN Address Line 1 (Street Address or Apt/Suite#): ____________________

OB/GYN Address Line 2 (PO Box, Street Address): ____________________

City:____________________ State:__________ ZIP:__________

☐ Yes ☐ No Are you an established patient?

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

Selecting "yes" for the Health Savings Account (HSA) option authorizes Wellmark, Inc. to share the following information with WageWorks for the purposes of establishing an HSA. **Information to be disclosed to WageWorks 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 K below. WageWorks is a separate company offering HSA account services. WageWorks does not provide Wellmark Blue Cross and Blue Shield products or services and is solely responsible for any services it provides.

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.

G. OPTIONAL BENEFITS

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 your existing policy.

Blue Dental ☐ Yes ☐ No

Avesis Vision ☐ Yes ☐ No

(**Note:** Vision can only be elected if you also elected health. This vision coverage is only available to members 19 and over. Pediatric vision is included in the health benefits.)

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.

H. CANCELLATION

I am requesting cancellation of:

☐ my entire policy effective _____/ 1 /_____

☐ medical health plan ONLY (I understand that if I have vision coverage, it will also be cancelled with my health plan.)

☐ Blue Dental coverage

☐ Avesis Vision coverage

I understand Wellmark does not allow cancellation on odd dates and the earliest available cancellation date is the 1st 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 benefits for any member under age 19 included in my health coverage, these vision benefits will be cancelled with my health coverage. To cancel automatic acount 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.

Existing Policyholder Name *(First, Middle, Last)*	Wellmark Policyholder Member Identification (ID) Number

I. BILLING INFORMATION

1. Will your employer be paying any part of the premium or fee for this policy? ☐ Yes ☐ No

   If "yes":

   1a. Are you a sole proprietor purchasing coverage only for yourself or yourself and spouse/dependents, and not purchasing coverage for any common law employees? ☐ Yes ☐ No

   1b. Is your premium being paid by your employer through after tax wage adjustments or payroll deduction? ☐ Yes ☐ No

2. How do you want to pay for your health premiums and service fees? **Please do not send payment with this form.**

   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 Policyholder's account.**

   ☐ 3. **Automatic Account Withdrawal from account other than Policyholder'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 service fees withdrawn from your savings account, please complete Form M-5779.)*

Attach a voided check to a separate piece of paper OR complete the following information:

Financial Institution Name: ______________________________

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

Financial Institution Routing Number (9 digits): ______________________________

Account Number: ______________________________

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 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)*	Wellmark Policyholder Member Identification (ID) Number

J. EFFECTIVE DATES

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

Event:	**Effective Date:**
Annual open enrollment period	Assigned in accordance with federal guidance. You can obtain further information by calling Wellmark Customer Service at 800-978-3221 or your authorized agent.
Birth	Date of birth
Adoption, placement for adoption or foster child placement	Date of adoption, placement for adoption or foster child placement
Legal Guardianship	Date of event
Court-ordered coverage	Date of event
Marriage / Common law	1st of the month following the event
Domestic partnership	1st of the month following the event
Returning from Military Service	1st of the month following the event
Gained U.S.A. Citizenship	1st of the month following the event
Permanent move to Iowa	1st of the month following the event
Employer renewal date is outside of the annual open enrollment period for an Individual Health Plan	1st of the month following the event
Involuntary loss of creditable coverage*	1st of the month following the event

*Loss of creditable coverage includes:

- Death of Policyholder
- Divorce/Dissolution of Domestic Partnership
- Exhaustion of COBRA
- Loss of employer group coverage or loss of employer contribution to group coverage
- Loss of Medicaid or *hawk-i* eligibility
- Loss of minimum essential coverage
- No longer a dependent
- Policyholder enrolls in Medicare
- Termination of employment/reduction in hours

K. 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. If I am electing a Blue Rewards plan, I understand that as a condition of eligibility for benefits, the policyholder covered under this Blue Rewards plan must maintain his/her residency in an Iowa county offering the plan I have selected. I understand that some of Wellmark's plans are not available in all counties. Failure to maintain such residency by the policyholder named in this application will give Wellmark Health Plan of Iowa, Inc. the right to terminate the coverage specified in this application 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.

Coverage Effective Date
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 J for effective date information.

Tobacco User Status
If I answered “No” to the tobacco user question for any person age 18 and older 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)*	Wellmark Policyholder Member Identification (ID) Number

K. AUTHORIZATION , CERTIFICATION AND SIGNATURE, cont'd.

Dental Exclusions Period
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 benefits policy must provide benefits primary to Medicare.

myBlue HSA℠
In the event I have selected myBlue HSA℠ coverage on this form, 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.

If I answered "yes" in Section F above to authorize WageWorks to contact me, I understand I will receive guidelines and instructions from WageWorks 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. I understand I may be required to disclose additional information such as residential address to establish the HSA bank account. Questions regarding eligibility can be directed to WageWorks.

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 subject to federal health information privacy laws. The authorization will remain in effect until my information is submitted to WageWorks. 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 WageWorks before the revocation was received.

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.

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 Wellmark receives my written notification to cancel automatic account withdrawal by the 10th of the month. 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 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 serviced 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)*	Wellmark Policyholder Member Identification (ID) Number

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. If I am electing a Blue Rewards plan, I certify that I am a resident of an Iowa county offering the plan I have selected.

Existing Policyholder Signature X____ Date ______/______/______

New Policyholder Signature, if applicable X ________________________________ Date ______/______/______

Parent/Legal Guardian Signature (if applicant is a minor) X______________________ Date ______/______/______

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

Agent Printed Name X__________________________________ Agent No. | | | | | | | | |

Agent Signature, if applicable X ______________________________________ Date ______/______/______

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