Wellmark

Wellmark Blue Cross and Blue Shield of Iowa and Wellmark Health Plan of Iowa, Inc. are independent licensees of the Blue Cross and Blue Shield Association.

PO Box 14527
Des Moines, Iowa 50306-3527

Application for Individual Health, Dental, and Vision Insurance

(For plans effective 1/1/2016 and after)

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 form required)

Physical Home Address _____

Apartment or Suite Number _____

City _____ State _____ ZIP _____

Provide name of county in which applicant resides:

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

Address Line 2 (PO Box, Street Address) _____

City _____ State _____ ZIP _____

Preferred Phone Number:
( )

Email (optional):

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]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 provide it 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]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 form required.

For Office Use Only	Date Received

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

A. MEMBERSHIP INFORMATION, cont'd

☐ 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 _____

Note: If applicable, please provide the legal documentation.

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 the application to provide that additional information.

B. MEDICARE COVERAGE

☐ Yes ☐ No Are you and/or anyone 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): _____/_____/_____

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℠
☐ 5000 PPO	☐ 2500 PPO ☐ 4000 PPO ☐ 3000 PPO ☐ Max 5000 PPO	☐ 500 PPO ☐ Max 2750 PPO ☐ 1250 PPO	☐ 2000 PPO ☐ 5950 PPO ☐ 3350 PPO

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

SimplyBlue℠	CompleteBlue℠	EnhancedBlue℠	myBlue HSA℠	Blue Rewards℠
☐ 5000 HMO	☐ 2500 HMO ☐ 3000 HMO ☐ 4000 HMO ☐ Max 5000 HMO	☐ 500 HMO ☐ 1250 HMO ☐ Max 2750 HMO	☐ 2000 HMO ☐ 3350 HMO ☐ 5950 HMO	☐ 1000 ☐ 5500 ☐ 1500

2. Select your dental and/or vision 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

Vision/Hearing (Avesis*) ☐ 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.

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 coverage options by county, visit Wellmark.com or contact an agent.

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

C. ENROLLMENT INFORMATION, cont'd

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.

H. Personal Doctor: Please choose a Personal Doctor for each member of your family. This information is required for applicants choosing an HMO (Wellmark Health Plan of Iowa, Inc.) or Blue Rewards℠ plan, including family members who live outside the network area (for example, those who are under age 26 and remain on a parent's plan). The personal doctor designation is not for applicants who permanently live outside of Iowa. You can choose from among five different provider types: General/Family Practice Physicians, Internists, Nurse Practitioners, Physician Assistants, or Pediatricians. The personal doctor you choose must participate in the network associated with your plan. In addition, female members may choose an OB/GYN. You can access the Wellmark provider directory at wellmark.com/HealthAndWellness/FindaDoctor/FindaDoctor.aspx or by calling 1-800-978-3221. You may also see a Personal Doctor referred to as a Primary Care Provider (PCP) in other Wellmark documentation. (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

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?

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?

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?

☐ I certify that I am legally authorized to list a personal doctor for myself and for all persons named in this section.

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

C. ENROLLMENT INFORMATION, cont'd

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

If "yes:"

3a. Are you a sole proprietor purchasing coverage only for yourself, yourself and spouse/dependents, and not purchasing coverage for any common law employee?
☐ Yes ☐ No

3b. Is your premium being paid by your employer through after-tax wage adjustments or payroll deductions?
☐ Yes ☐ No

Note: If you answered "yes" to number 3 and "no" to both 3a and 3b — you are not eligible to apply for individual coverage.

D. 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 (Street Address or Apt/Suite#) _____

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 canceled.

To remove a member(s) but not cancel the entire policy, please call 800-978-3221.

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.**

Note: State and federal law prohibits an employer from contributing to the payment of employees' premiums for this plan unless: 1) the applicant is the sole proprietor or owner of a sole proprietorship, or 2) the premium is being paid by the employer through after-tax wage adjustments or payroll deduction.

If another party is to pay premiums on your behalf through an Automatic Account Withdrawal, submit the Individual Automatic Payment Authorization Form (M-2318361).

If you checked 2 please complete the following:

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

Date of withdrawal: All withdrawals will be made on the 5th of the month.

From: ☐ Checking
☐ Savings *(If you want to have premiums and fees withdrawn from your savings account, please complete Form M-2318361.)*

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

E. PAYMENT INFORMATION, cont'd

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 _____

I hereby authorize Wellmark to make automatic withdrawals from the account shown in the amount of my periodic premium payment and related fees, 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, in order to stop your next scheduled withdrawal, 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 the box prior to applicable event:

Add or remove applicant or non-applicant household member listed on application

- ☐ Marriage, including common law
- ☐ Domestic Partner (include Certification of Domestic Partnership form)
- ☐ Birth
- ☐ Adoption/foster care
- ☐ Legal guardianship
- ☐ Court ordered coverage

The events above, with the exception of marriage or domestic partnership, will result in new coverage effective as of the date of the event, if Wellmark is notified within the applicable notification time period. The coverage effective date for marriage or domestic partnership will be the 1st of the month following notice or the 1st of the second month following notice, based on the Wellmark receipt date, as further described below.

☐ **Access to qualified health plan due to a permanent move**

Loss of other health coverage

- ☐ Death of a policyholder/certificate holder
- ☐ Dependent turning 26
- ☐ Dependent 19-25
- ☐ Divorce/dissolution of domestic partnership
- ☐ Exhaustion of COBRA
- ☐ Loss of Medicaid or Hawk-I eligibility
- ☐ Policyholder or certificate holder enrolls in Medicare
- ☐ Termination of employment or reduction in hours
- ☐ Return from military service

☐ **Newly eligible or ineligible for subsidy due to increase or decrease in projected current income or current month's income**

Change in immigration status or citizenship

- ☐ Gained U.S. Citizenship
- ☐ Obtain Legal Immigration Status

Changes to available employer coverage

- ☐ Loss of group coverage
- ☐ Employer renewal date is outside of an annual open enrollment period for the Individual Health Plan market

These special enrollment events will result in coverage effective the 1st of the following month if Wellmark is notified between the first and 15th of the month. If Wellmark is notified on the 16th of the month or later, the coverage effective date will be the 1st of the second month following notice. This may result in a period of time where you don't have health insurance coverage. If you experience a gap in coverage, your annual deductible and out of pocket maximum amounts will not be carried over to your new plan. If you want continuous coverage, please call 800-978-3221.

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

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 the 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]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 provide it for each person listed. Failure to provide the SSN/TIN information may result in a $50 penalty, per violation, assessed to you be 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]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 or POA information for any of your dependents, please provide information on a separate sheet of paper.

I. APPLICATION AGREEMENT AND CERTIFICATION

I certify that I am a resident of Iowa, and 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 of approval of coverage.

If applicable, for my convenience I authorize Wellmark to automatically use 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. 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 where the plan I’ve selected is offered by Wellmark. 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 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 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
Refer to Section F above for the effective date applicable to each qualifying 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,

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

I. APPLICATION AGREEMENT AND CERTIFICATION, cont'd

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 to authorize WageWorks to contact me, I will receive guidelines and instruction from WageWorks for completing the opening of my HSA account. Please review enrollment materials carefully; it is the individual's responsibility to validate eligibility for an HSA account. You may be required to disclose additional information such as a 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.

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 my coverage status to the federal government, 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 Wellmark will be unable to report and send the information needed to complete federal tax returns. If I have not previously provided 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. If I do not provide the Social Security numbers or tax 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

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.

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

I. APPLICATION AGREEMENT AND CERTIFICATION, cont'd

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.

The Member may cancel automatic payment or provide the Member's new/updated banking information any time by notifying Wellmark in writing or by calling the number on the Wellmark ID card by the 10th of the month prior to the next scheduled withdrawal. A Bank Account Holder other than the Member must provide written notification by the 10th of the month prior to the next scheduled withdrawal in order to cancel automatic payment or provide new/updated banking information. If the request is not received by the 10th of the month prior to the next scheduled withdrawal, request may not be processed before the next withdrawal. **The Member or Bank Account Holder will be responsible for any fee assessed by the bank for insufficient funds or stop-payment orders made.**

If at any time the Member's account falls behind in payments, Wellmark reserves the right to withdraw any amount necessary, including fees, to bring the Member's account current with the next regularly scheduled automatic payment. Wellmark will not withdraw any amount above that which is due at the time of withdrawal; notice may not be provided to either the Member or the Bank Account Holder prior to said withdrawal.

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.

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 my selected plan.

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.

Consent to Receive Marketing Information and Solicitations Via Residential Telephone, Cellular Phone, Text, and Email Messages
By checking the box later in this application, and entering my signature on this application, I hereby provide my consent to Wellmark to contact me about Wellmark products and services that may be available to me. Wellmark may provide this information to me using residential telephone, cellular telephone or wireless device, text message, or email contact information provided to Wellmark from time to time. If I provide a telephone number for voice calls, I understand that Wellmark may contact me via live or prerecorded calls. I give Wellmark permission to use my personal data (including personally identifiable information) in accordance with Wellmark's privacy policy to determine the types of products and services that may be offered to me. I understand the telephone company or other communications carrier may impose charges for these contacts and that I am not required to give this consent to purchase any goods or service. I understand I may revoke this consent at any time by calling 800-978-3221.

Consent to Electronic Delivery of Information
By checking the box in this application, and entering my signature on this application, I hereby provide my consent to Wellmark to deliver important notices and information about my health plan and coverage electronically. I understand I am being asked to consent to notices and documents being delivered to me electronically. My consent applies to notices and documents relating to my health insurance coverage ("Coverage") with Wellmark.

Right to Request for Paper Copies
I understand that I have a right to have a notice or document provided or made available in paper form at no cost. To obtain a paper copy of a notice or document delivered by electronic means, or to withdraw consent, please contact Wellmark at 800-978-3221.

Right to Withdraw Consent
I understand I have a right to withdraw consent to have a notice or document delivered by electronic means. Such consent will be deemed withdrawn upon receipt by Wellmark of the request to withdraw consent. Any withdrawal of consent shall not affect the legal effectiveness, validity or enforceability of a notice or document delivered by electronic means before the withdrawal of consent is effective. To withdraw consent to electronic notice of documents please contact Wellmark at 800-978-3221 or select the "unsubscribe" option located within the email message.

Scope of Consent

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

I. APPLICATION AGREEMENT AND CERTIFICATION, cont'd

This consent applies to all notices and documents relating to my Coverage, including, but not limited to:

- Explanation of Benefits;
- Disclosures and notices;
- Summary of Benefits and Coverage;
- Notices of cancelation, nonrenewal or termination;
- Benefits Policy, riders and endorsements;
- Responses to communications from you;
- Appeals correspondence;
- Billing and payment notices; and
- Other important information

Hardware and Software Requirements
In order to access, view, and retain documents electronically, I understand I must have, or have access to, a personal computer or other device that is capable of accessing the internet with an internet web browser, email or web service capabilities, the ability to receive and review attachments to emails, and software which permits me to receive and access Portable Document Format (PDF) files and MS Word files. Free software to view PDF files is available from: http://get.adobe.com/reader/. By providing this Consent, I confirm that I have, or have access to, the hardware and software identified above necessary to receive and review electronic records, and that I have an active email account with the ability to receive and access emails and email attachments in the formats described above.

NOTICE/DISCLAIMER
WELLMARK IS NOT RESPONSIBLE FOR ANY UNAUTHORIZED ACCESS BY THIRD PARTIES TO INFORMATION PROVIDED ELECTRONICALLY, INCLUDING, WITHOUT LIMITATION, ANY DIRECT, INDIRECT, SPECIAL, INCIDENTAL OR CONSEQUENTIAL DAMAGES RESULTING FROM SUCH UNAUTHORIZED ACCESS. WELLMARK ALSO IS NOT RESPONSIBLE FOR DELAYS IN TRANSMISSION OF NOTICES AND DOCUMENTS.

CONSENT
By accessing or opening the documents sent to me via the email address provided, I certify that (1) I consent and agree to receive notices and documents electronically and confirm that I will download or print them for my records; and (2) I have the ability to access the information that is provided electronically via email communications.

☐ I give permission to the licensed agent/licensed agency who is identified with this application to enter my application online through *Wellmark.com*.
☐ I Authorize Wellmark to contact me via residential telephone, cellular phone, text, and/or email for marketing and information purposes (**Optional**)
☐ I Consent to receive important information electronically (**Optional**)

Applicant Signature X _____ 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 Signature X _____ Date: _____/_____/_____

Agent's Printed Name _____

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

Agent Phone Number (optional) _____

Authorization to Use/Disclose Protected Health Information for Marketing Purposes
I authorize Wellmark to use and/or disclose protected health information about me including my name, contact and enrollment and claims information for marketing, promotional, education and information purposes, included contacting me about products and services offered by Wellmark. I understand that (1) I may refuse to provide this authorization and that it is strictly voluntary; (2) If I do not sign this form, my health care and the payment for my health care will not be affected; (3) I may revoke this authorization at any time in writing or by calling 800-978-3221, but if I do, it will not have an effect on any actions taken prior to receiving the revocation; (4) If the recipient of the information is not a health plan or health care provider, such information may no longer be protected by federal privacy regulations and may be re-disclosed; (5) I understand that I may see and obtain a copy of the information described on this form upon request; and (6) I may have a copy of this form if requested. This authorization will remain in effect until the earlier of my revocation or the termination of my coverage with Wellmark.

☐ I Authorize Wellmark to use/disclose Protected Health Information for Marketing Purposes (**Optional**)

Applicant Signature: _____

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
Application Processing Center
PO Box 30150
Tampa, FL 33630-0150
OR
Fax to: 844-820-0939

Required Federal Accessibility and Nondiscrimination Notice

Discrimination is against the law

Wellmark complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. Wellmark does not exclude people or treat them differently because of their race, color, national origin, age, disability or sex.

Wellmark provides:

- Free aids and services to people with disabilities so they may communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, call 800-524-9242.

If you believe that Wellmark has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance with: Wellmark Civil Rights Coordinator, 1331 Grand Avenue, Station 5W189, Des Moines, IA 50309-2901, 515-376-4500, TTY 888-781-4262, Fax 515-376-9073, Email CRC@Wellmark.com. You can file a grievance in person, by mail, fax or email. If you need help filing a grievance, the Wellmark Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail, phone or fax at: U.S. Department of Health and Human Services, 200 Independence Avenue S.W., Room 509F, HHH Building, Washington DC 20201, 800-368-1019, 800-537-7697 (TDD).

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

ATENCIÓN: Si habla español, los servicios de asistencia de idiomas se encuentran disponibles gratuitamente para usted. Comuníquese al 800-524-9242 o al (TTY: 888-781-4262).

注意：如果您说普通话，我们可免费为您提供语言协助服务。请拨打 800-524-9242 或（听障专线：888-781-4262）。

CHÚ Ý: Nếu quý vị nói tiếng Việt, các dịch vụ hỗ trợ ngôn ngữ miễn phí có sẵn cho quý vị. Xin hãy liên hệ 800-524-9242 hoặc (TTY: 888-781-4262).

NAPOMENA: Ako govorite hrvatski, dostupna Vam je besplatna podrška na Vašem jeziku. Kontaktirajte 800-524-9242 ili (tekstualni telefon za osobe oštećena sluha: 888-781-4262).

ACHTUNG: Wenn Sie deutsch sprechen, stehen Ihnen kostenlose sprachliche Assistenzdienste zur Verfügung. Rufnummer: 800-524-9242 oder (TTY: 888-781-4262).

تنبيه: إذا كنت تتحدث اللغة العربية، فإننا نوفر لك خدمات المساعدة اللغوية، المجانية. اتصل بالرقم 800-524-9242 أو (خدمة الهاتف النصي : 888-781-4262).

ສ່ຽງຄວນເອົາໃຈໃສ່, ພາສາລາວ ຖ້າທ່ານເວົ້າ: ພວກເຮົາມີບໍລິການຄວາມຊ່ວຍເຫຼືອດ້ານພາສາໃຫ້ທ່ານໂດຍບໍ່ເສຍຄ່າ ຫຼື 800-524-9242 ຕິດຕໍ່ຫາ. (TTY: 888-781-4262.)

주의: 한국어 를 사용하시는 경우, 무료 언어 지원 서비스를 이용하실 수 있습니다. 800-524-9242번 또는 (TTY: 888-781-4262)번으로 연락해 주십시오.

ध्यान रखें : अगर आपकी भाषा हिन्दी है, तो आपके लिए भाषा सहायता सेवाएँ, निःशुल्क उपलब्ध हैं। 800-524-9242 पर संपर्क करें या (TTY: 888-781-4262)।

ATTENTION : si vous parlez français, des services d'assistance dans votre langue sont à votre disposition gratuitement. Appelez le 800 524 9242 (ou la ligne ATS au 888 781 4262).

Geb Acht: Wann du Deitsch schwetze duscht, kannscht du Hilf in dei eegni Schprooch koschdefrei griege. Ruf 800-524-9242 odder (TTY: 888-781-4262) uff.

โปรดทราบ: หากคุณพูด ไทย เรามีบริการช่วยเหลือด้านภาษาสำหรับคุณโดยไม่คิดค่าใช้จ่าย ติดต่อ 800-524-9242 หรือ (TTY: 888-781-4262)

PAG-UKULAN NG PANSIN: Kung Tagalog ang wikang ginagamit mo, may makukuha kang mga serbisyong tulong sa wika na walang bayad. Makipag-ugnayan sa 800-524-9242 o (TTY: 888-781-4262).

တ၀်ဒုးသ့ဉ်ညါ–နမ့်ကတိၤကညီကျိာ်.ကျိာ်တ်မၤစၤတ်ဖံးတ်မၤတဖဉ်.လၢတဘဉ်လာ်ဘူးလဲ.အိဉ်လၢနဂီၢ်လီၤ. ဆဲးကျိးဆူ၀၀–၅၂၄–၉၂၄၂မ့တမ့်(TTY:၈၈၈–၇၈၁–၄၂၆၂)တက့ာ်.

ВНИМАНИЕ! Если ваш родной язык русский, вам могут быть предоставлены бесплатные переводческие услуги. Обращайтесь 800-524-9242 (телетайп: 888-781-4262).

सावधान: यदि तपाईं नेपाली बोल्नुहुन्छ भने, तपाईंका लागि निःशुल्क रूपमा भाषा सहायता सेवाहरू उपलब्ध गराइन्छ। 800-524-9242 वा (TTY: 888-781-4262) मा सम्पर्क गर्नुहोस्।

ማሳሰቢያ: አማርኛ የሚናገሩ ከሆነ፣ የቋንቋ አገዛ አገልግሎቶች፣ ከክፍያ ነፃ፣ ያገኛሉ። በ 800-524-9242 መደም (በTTY: 888-781-4262) ይውለው ያነጋግሩን።

HEETINA To a wolwa Fulfulde laabi walliinde dow wolde, naa e njobdi, ene ngoodi ngam maaɗa. Heɓir 800-524-9242 malla (TTY: 888-781-4262).

FUULEFFANNAA: Yo isin Oromiffaa, kan dubbattan taatan, tajaajiloonni gargaarsa afaanii, kaffaltii malee, isiniif ni jiru. 800-524-9242 yookin (TTY: 888-781-4262) quunnamaa.

УВАГА! Якщо ви розмовляєте українською мовою, для вас доступні безкоштовні послуги мовної підтримки. Зателефонуйте за номером 800-524-9242 або (телетайп: 888-781-4262).

Ge': Diné k'ehjí yáníłti'go níká bizaad bee áká' adoowoł, t'áá jiik'é, náhóló. Kojį' hólne' 800-524-9242 doodaii' (TTY: 888-781-4262)

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