Wellmark Blue Cross and Blue Shield of Iowa is an independent licensee of the Blue Cross and Blue Shield Association.

State of Iowa Retiree Programs N, F, Iowa Choice and National Choice Group Application

Iowa Department of Administrative Services
Human Resources Enterprise - Retirement
Hoover State Office Building - Level A
1305 E Walnut
Des Moines, Iowa 50319

APPLICANT: DO NOT COMPLETE SHADED AREA

Group/Section No.	Group No. Key	Effective Date
		_____/_____/_____

A. NAME, ADDRESS AND COVERAGE

Name (Last, First)

Telephone Number	Social Security Number (Required)	Gender ☐ Male ☐ Female	Date of Birth _____/_____/_____

Address (Street, Apt No./Suite No., PO Box, City, State, ZIP)	Social Security Disabled ☐ Yes ☐ No	Medicare Enrolled ☐ Yes ☐ No

Email Address

Please select one of the retiree programs.[1] Coverage begins on the assigned effective date.

Type of Benefits Desired ▶ ☐ **Program N** ☐ **Program F*** ☐ **Iowa Choice** ☐ **National Choice**

[1]If you select Program N or F you must be Medicare eligible and you cannot add family members.

*If enrolling a member and spouse, there will need to be a completed application for both the member and the spouse.

B. MEMBERS/ENROLLEES COVERED

Complete this area only if requesting family coverage. List all other persons to be covered on your family contract.

MUST COMPLETE IF APPLICABLE

Name (First, Last)	Date of Birth mm/dd/yyyy	Gender	Social Security Number (Must Complete)	Student or Disabled	Soc. Sec. Disabled	Medicare Enrolled
Spouse or Domestic Partner	_____/_____/_____	☐ Male ☐ Female		☐ Student ☐ Disabled	☐ Yes ☐ No	☐ Yes ☐ No
Dependent	_____/_____/_____	☐ Male ☐ Female		☐ Student ☐ Disabled	☐ Yes ☐ No	☐ Yes ☐ No
Dependent	_____/_____/_____	☐ Male ☐ Female		☐ Student ☐ Disabled	☐ Yes ☐ No	☐ Yes ☐ No
Dependent	_____/_____/_____	☐ Male ☐ Female		☐ Student ☐ Disabled	☐ Yes ☐ No	☐ Yes ☐ No

C. EVENT(S) OR REASON(S) FOR CHANGING CONTRACT

If you selected Program N or F the following are the acceptable events or reasons for changing contract.

		Date of Event	Explanation:
☐ Married ☐ Annual enrollment ☐ Divorce ☐ Retirement	☐ Loss of other coverage ☐ Eligible for Medicare ☐ Other	_____/_____/_____	

D. MEDICARE COVERAGE

Name of person covered by Medicare (as it appears on Medicare card)

Medicare ID	Effective Date (Part A)	Effective Date (Part B)	Effective Date (Part D)
	_____/_____/_____	_____/_____/_____	_____/_____/_____

D. MEDICARE COVERAGE, cont'd

Spouse or Domestic Partner Name (as it appears on Medicare card)

Medicare ID	Effective Date (Part A) _____/_____/_____	Effective Date (Part B) _____/_____/_____	Effective Date (Part D) _____/_____/_____

Dependent Name (as it appears on Medicare card)

Medicare ID	Effective Date (Part A) _____/_____/_____	Effective Date (Part B) _____/_____/_____	Effective Date (Part D) _____/_____/_____

E. OTHER CARRIER INFORMATION

If you or your spouse/domestic partner or anyone named in this application has hospital, medical, or prescription drug coverage insurance through another group plan (either directly or through your spouse) where the employer or group sponsor pays any portion of the cost or makes payroll deductions, please complete the following:

☐ Yes ☐ No Will you keep other health coverage in addition to this Wellmark coverage?

☐ Yes ☐ No In a divorce situation, has a divorce decree required one parent to be primarily responsible for health insurance for any of the above listed dependents?

Who is covered by the other health plan?
☐ Self ☐ Spouse or domestic partner ☐ Dependent(s) Effective date: _____/_____/_____

Policy Number:_____

Name (First, Last):_____

Employer (if applicable):_____

Insurance Company/HMO Name and Address:_____

F. METHOD OF PAYMENT

Select how you would like to pay for your premiums from one of the options below. Billing periods are based on a calendar year. Please do not send payment with this application. If the bank account holder is not present to sign the application, you will need to complete and submit an Automatic Payment Authorization Form (M-5779).

☐ New or update payment information ☐ Use payment information on file

Payer's Billing Information (if different from applicant's mailing address):

Payer's Name_____

Payer's Mailing Address (Include Street, Bldg Name/No., Apt. No.)_____

PO Box_____ City_____ State_____ ZIP_____

1. Direct bill. ☐
If so, on what basis? ☐ Monthly ☐ Quarterly ☐ Semi-annually ☐ Annually

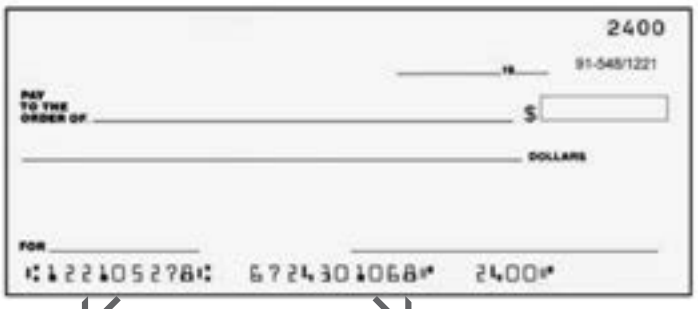
2. Automatic account withdrawal from Applicant's account. ☐

3. Automatic account withdrawal from Account other than applicant's. ☐

If you selected payment method 2 or 3, please complete the following:
On what basis: ☐ Monthly ☐ Quarterly ☐ Semi-annually ☐ Annually

Date of withdrawal: ☐ First of the month ☐ Fifth of the month

From: ☐ Checking ☐ Savings



9-Digit Bank Routing Number | **Bank Account Number**

** Please sign page 5 and retain a copy of this application for your records. **

F. METHOD OF PAYMENT, cont'd

Complete the following information:

Financial Institution Name:_____

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

If direct bill is ***not*** selected:

As the bank account holder, I hereby authorize Wellmark to make automatic withdrawals from the account provided in section F in the amount of my periodic premium payment as it may be adjusted from time to time.
If the undersigned is not the applicant, I understand and agree that notices of any premium adjustments when provided to the applicant shall constitute notice to the undersigned of any such adjustment. I hereby certify that I have read and understand the provisions of the Authorization and Certification section. This authorization shall supersede and replace any previous authorization given by me for automatic premium withdrawal.

Bank Account Holder's Signature (if other than applicant):_____ Date:_____/_____/_____

You may cancel automatic account withdrawal at any time. However, we need to receive your written notification at least 20 days before your scheduled withdrawal.

G. WAIVER OF ENROLLMENT (PLEASE COMPLETE IF YOU ARE WAIVING HEALTH BENEFITS)

☐ I waive health coverage for myself, and/or my dependents. 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.

H. 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 Services, Wellmark, Inc., PO Box 9232, Mail Station 3W294, Des Moines, IA 50306-9232, or call 800-524-9242.

I. AUTHORIZATION AND CERTIFICATION (if enrolling in Program N or F)

I certify that I am legally authorized to apply for coverage. I understand that I am completing this application for the coverages sponsored by the State of Iowa offered by Wellmark, Inc., doing business as Wellmark Blue Cross and Blue Shield of Iowa (referenced herein as "Wellmark"). I understand that written notice of rate changes will be furnished by the State of Iowa as my agent. I further understand that the coverage applied for will not start until after this application and the appropriate premiums are received and accepted by Wellmark and an effective date of coverage is established by Wellmark.

I understand that premium payments may be made on a calendar month, calendar quarter, semi-annual calendar year or calendar year basis. For example, a monthly premium payment would be for the first day of a month through the last day of such month. A quarterly premium payment would be for any calendar quarterly period, such as January 1 through March 31. A semi-annual premium would be for the period of either January 1 through June 30 or July 1 through December 31. An annual premium payment would be from January 1 through December 31 of the applicable year.

In the event I choose to pay my premium on a quarterly, semi-annual or annual basis and there is a mid-year increase in the amount of the premium(s) I will have the following responsibility with regard to an increase in premium(s).

- Quarterly payments: For quarterly premium payments, I must pay the remaining quarterly premium payments that include the premium increase.
- Semi-annual payments: For semi-annual premium payments, I must pay a bill for a premium payment that equals the difference between the new semi-annual premium amount and the previously paid first semi-annual premium amount. I also will be required to pay a second semi-annual premium amount that includes the premium increase.
- Annual payment: For annual premium payments, I must pay a bill for a premium payment that equals the difference between the new annual premium amount and the previously paid annual premium amount.

I. AUTHORIZATION AND CERTIFICATION (IF ENROLLING IN PROGRAM N OR F), cont'd

My signature additionally verifies that I understand and agree that the amount of my periodic premium 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), or other factors that require adjustments to the total premium. These changes may occur at times other than an annual 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. My authorization for automatic premium withdrawal 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 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 intentionally made any false statements or misrepresentations, or have failed to disclose or concealed any material fact, Wellmark will be entitled to declare the contract applied for void and to refuse allowance on benefits to any person thereunder.

My signature also verifies that I authorize any health care provider to release medical records to Wellmark Blue Cross and Blue Shield of Iowa when reasonably related to the health insurance coverage for which I have applied. If any law or regulation requires additional authorization for release of medical records, I will give this authorization.

J. AUTHORIZATION AND CERTIFICATION (if enrolling in Iowa Choice or National Choice)

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 completing this 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 here in as "Wellmark"). I understand that written notice of rate changes will be furnished by 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 give, 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 of benefits to any person thereunder.

I acknowledge that I have received or will receive from my employer the Summary of Benefits and Coverage (SBC). 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 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 a 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 informatin. Wellmark maintains the confidentiality of **all** information received and it will not be released to any person or facitliy. 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 then has the right to condition eligibility determination and enrollment on the receipt of this signed authorization.

Consent to Contact Me Via Residential Telephone, Cellular Phone, Text and Email Messages

☐ By checking this box and entering my signature on this application, I hereby provide my consent to Wellmark to contact me about my Wellmark policy or 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

J. AUTHORIZATION AND CERTIFICATION (if enrolling in Iowa Choice or National Choice), cont'd

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 services. I understand I may revoke this consent at any time by calling the number located on the back of my Wellmark ID card.

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** _____/_____/_____

Wellmark®

Wellmark Language Assistance

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, including sex characteristics, including intersex traits; pregnancy or related conditions; sexual orientation; gender identity, and sex stereotypes. Wellmark does not exclude people or treat them less favorably because of race, color, national origin, age, disability, or sex.

Wellmark

- Provides people with disabilities reasonable modifications and free appropriate auxiliary aids and services to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats).
- Provides free language assistance services to people whose primary language is not English, which may include:
  - Qualified interpreters
  - Information written in other languages

If you need reasonable modifications, appropriate auxiliary aids and services, or language assistance 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 3E417, Des Moines, IA 50309-2901, 515-376-6500, TTY 888-781-4262, Fax 515-376-9055, Email **CRC@Wellmark.com**. You can file a grievance in person or 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 or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 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 ٨٠٠-٥٢٤-٩٢٤٢ أو (خدمة الهاتف النصي: ٨٨٨-٧٨١-٤٢٦٢).

ສິ່ງຄວນເອົາໃຈໃສ່, ພາສາລາວ ຖ້າທ່ານເວົ້າ: ພວກເຮົາມີບໍລິການຄວາມຊ່ວຍເຫຼືອດ້ານພາສາໃຫ້ທ່ານໂດຍບໍ່ເສຍຄ່າ ຫຼື 800-524-9242 ຕິດຕໍ່ທີ່. (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).

တၢ်ဒိးသ့ၣ်ညါ–နမ့ၢ်ကတိၤကညီကျိာ်,ကျိာ်တၢ်မၤစၢၤတၢ်ဖိးတၢ်မၤတဖၣ်,လၢတဘၣ်လၢာ်ဘူးလဲ,အိၣ်လၢနဂီၢ်လီၤ.ဆဲးကျိးဆူ ၈၀၀–၅၂၄–၉၂၄၂မ့တမ့ၢ်(TTY:၈၈၈–၇၈၁–၄၂၆၂)တက့ၢ်.

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 नि:शुल्क रूपमा भाषा सहायता सेवाहरू उपलब्ध गराइन्छ । 800-524-9242 वा (TTY: 888-781-4262) मा सम्पर्क गर्नुहोस् ।

ማሳሰቢያ፦ አማርኛ የሚናገሩ ከሆነ፣ የቋንቋ እገዛ አገልግሎቶች፣ ከክፍያ ነፃ፣ ያገኛሉ። በ 800-524-9242 ወይም (በTTY: 888-781-4262) ይደውለው 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, náhólǫ́. Kojį’ hólne’ 800-524-9242 doodaii’ (TTY: 888-781-4262)