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 9232
Des Moines, Iowa 50306-9232

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

State of Iowa Group Application for Iowa Choice and National Choice

A. NAME, ADDRESS AND COVERAGE

☐ New Hire ☐ Late Enrollee ☐ Special Enrollee ☐ Change

Name (Last, First)	Telephone Number	Social Security Number (Required)

Residence (No.) (Street Or Rfd No.) (City) (State) (ZIP)	Status	Date of Birth
	☐ Single ☐ Common Law (Notarized Affidavit Required) ☐ Married ☐ Domestic Partner (Notarized Affidavit Required)	_____/_____/_____

Employee Status	Date Employed	Gender	Soc. Sec. Disabled?	Medicare Enrolled?
☐ Full-Time ☐ Retiree ☐ Part-Time ☐ COBRA	_____/_____/_____	☐ Male ☐ Female	☐ Yes ☐ No	☐ Yes ☐ No

Type of Benefits Desired ▶	☐ Iowa Choice ☐ National Choice Coverage Does Not Start Until An Effective Date Is Assigned

B. CONTRACT INFORMATION

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?
1. Please List Your Spouse or Domestic Partner Here If Family Contract ▶	Spouse or Domestic Partner	____/____/____	☐ Male ☐ Female		☐ Student ☐ Disabled	☐ Yes ☐ No	☐ Yes ☐ No
And All Eligible Dependents Here If Family Contract	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

☐ Married ☐ Birth/adoption ☐ Death ☐ Divorce ☐ Change of spouse's or domestic partner's employment ☐ Other	Date of Event ____/____/____	Explanation

D. MEDICARE COVERAGE

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

Medicare Part A Effective Date _____/_____/_____ Medicare Part B Effective Date _____/_____/_____ Medicare Part D Effective Date _____/_____/_____

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

Medicare Part A Effective Date _____/_____/_____ Medicare Part B Effective Date _____/_____/_____ Medicare Part D Effective Date _____/_____/_____

Dependent Name (as it appears on Medicare card): _____ Medicare ID _____

Medicare Part A Effective Date _____/_____/_____ Medicare Part B Effective Date _____/_____/_____ Medicare Part D Effective Date _____/_____/_____

E. OTHER CARRIER INFORMATION

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

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

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

Policy Number: _____ Who is covered by the other health plan?

Policyholder Name (First, Last): _____ ☐ Self ☐ Spouse or Domestic Partner

Employer (if applicable): _____ ☐ Dependent(s)

Insurance Company/HMO Name and Address: _____ Effective Date: _____/_____/_____

F. PRIOR COVERAGE INFORMATION

☐ Yes ☐ No New Hire: Did you, your spouse or domestic partner, or your dependents have health coverage 63 days prior to the hire date stated above?

☐ Yes ☐ No Special Enrollee/Late Enrollee: Did you, your spouse or domestic partner, or dependents have health coverage within 63 days prior to the effective date of this coverage? If yes, please complete:

Name of Insurance Company: _____ Policy Number: _____

Covered Person(s): _____ Effective Date: _____/_____/_____ End Date: _____/_____/_____

G. CONSENT INFORMATION

Consent to receive Marketing Information and Solicitations 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 Wellmark policy or 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 services. I understand I may revoke this consent at any time by calling the number located on the back of my Wellmark ID card.

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, Station 3W294, Des Moines, IA 50306-9232, or call 800-524-9242.

I. AUTHORIZATION AND CERTIFICATION

I certify that I am legally authorized to apply for coverage for myself and all other persons named in this application. I understand that I am 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 herein 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 given, either expressly or by implication, has been knowingly withheld. I understand that Wellmark will rely on the completeness and truthfulness of the information given and the statements made, and that if I have made any false statements or misrepresentations, or have failed to disclose or concealed any material fact, Wellmark will be entitled to declare the contracts applied for void and to refuse allowance on benefits to any person thereunder.

I acknowledge 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 & 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 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 then has the right to condition eligibility determination and enrollment on the receipt of this signed authorization.

J. SIGNATURE

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

Applicant Signature_____ Date_____/_____/_____

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

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

Please see the Important Information Regarding Waiver of Enrollment section on this application.