

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 Effe		ctive Date		Des Moines, Iowa 50319					
					!						
A. NAME, AD	DRESS	AND CO	/ERAGE			,					
Name (Last, Fi	irst)										
Telephone Number			Social Secu	ırity Num			Gender Male		Date of Birth		
Address (Street, Apt No./Suite No., PO Box, Cit			ity, State	te, ZIP)			Social Security Disabled   Medicare Enrolled				
								☐ Yes ☐ No		☐ Yes ☐ No	
Email Address	i							•		1	
Please select one of the retiree programs.¹ Coverage begins on the assigned effective date.											
Type of	Progr	am N	Progran	ı F*		☐ lov	va Choice	National C	Choice		
Benefits	<sup>1</sup> If you select Program N or F you must be Medicare eligible and you cannot add family members.										
Desired						· · · · · · · · · · · · · · · · · · ·	•••	for both the member	er and the sp	ouse.	
B. MEMBERS coverage. List	S/ENROL all other p	LEES CO ersons to	<b>VERED</b> Co be covered	mplete tl on your 1	his ar family	ea only if re contract.	questing	family	MUST CO	MPLETE IF A	PPLICABLE
Nan	ne (First, La	ast)		Date of Birth mm/dd/yyyy		Gender		Social Security Number (Must Complete)		or Soc. Sec. d Disabled	Medicare Enrolled
Spouse or Domestic Partner					☐ Male ☐ Female			Studer Disable		☐ Yes ☐ No	
Dependent				//_		☐ Male ☐ Female			Studer Disable		☐ Yes ☐ No
Dependent			/		☐ Male ☐ Female				nt Yes ed No	☐ Yes ☐ No	
Dependent					☐ Male ☐ Female	е		☐ Studer ☐ Disable		☐ Yes ☐ No	
C. EVENT(S) If you selected F							ns for cha	nging contract.			
☐ Married       ☐ Loss of other coverage         ☐ Annual enrollment       ☐ Eligible for Medicare         ☐ Divorce       ☐ Other         ☐ Retirement					Date of Eve	vent Explanation:					
D. MEDICAR	E COVER	RAGE									
Name of perso	n covered	l by Medic	care (as it ap	pears or	Med	licare card)					
Medicare ID			Effective Date (Part A)		Effective Date (Part B)		Effective Date (Part D)				

D. MEDICARE COVERAGE, con	t'd				
Spouse or Domestic Partner Name	(as it appears on M	edicare card)			
Medicare ID		Effective Date (Pa	,	ve Date (Part B)	Effective Date (Part D)
Dependent Name (as it appears on	Medicare card)				
Medicare ID		Effective Date (Pa	art A) Effectiv	ve Date (Part B)	Effective Date (Part D)
E. OTHER CARRIER INFORMAT	ΓΙΟΝ		, , , , , , , , , , , , , , , , , , ,		•
If you or your spouse/domestic part insurance through another group p portion of the cost or makes payrol	lan (either directly of deductions, please	or through your sp complete the foll	ouse) where the owing:	e employer or gro	
Yes No Will you keep othe					
Yes No In a divorce situation any of the above listed depende	nts?	ecree required on	e parent to be p	rimarily responsi	ble for health insurance
Who is covered by the other health Self Spouse or domestic pa	rtner Depende				
Policy Number:					
Name (First, Last):					
Employer (if applicable):					
Insurance Company/HMO Name ar	nd Address:				
F. METHOD OF PAYMENT					
Select how you would like to pay fo Please do not send payment with the to complete and submit an Automa	nis application. If the	e bank account ho	lder is not pres		
Payer's Billing Information (if differ	ent from applicant's	s mailing address)	1		
Payer's Name					
Payer's Mailing Address (Include S	treet, Bldg Name/N	o., Apt. No.)			
PO Box C	ity		State		ZIP
1. Direct bill.   If so, on what basis?   Monthly	v	]Semi-annually	Annually		
2. Automatic account withdrawal	from Applicant's ac	count. 🗌			
3. Automatic account withdrawal	from Account other	than applicant's.			
If you selected payment method 2 On what basis: Monthly		ete the following: ni-annually   A	nnually		
Date of withdrawal: 🔲 First of t	he month 🔲 Fifth	of the month			
From: Checking Saving	s			24	00
			_	91-545/1	221
	TO THE	or		s	
				DOLLARS	
	ron			NUMBER OF STREET	
	(C.1.)	22105278: 6	724301068*	5400%	
	O District Control	<u>V</u>			
	9-Digit Bank Routing	g Number	Bank Acco	unt Number	

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 <i>not</i> selected:			
As the bank account holder, I hereby authorize Wellmark to make automatic withdrawals from the account 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 adjustment applicant shall constitute notice to the undersigned of any such adjustment. I hereby certify that I have the provisions of the Authorization and Certification section. This authorization shall supersede and reauthorization given by me for automatic premium withdrawal.	nts when presented and the second sec	provided d unders r previou	I to the stand is
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 days before your scheduled withdrawal.	n notificat	tion at le	ast 20
G. WAIVER OF ENROLLMENT (PLEASE COMPLETE IF YOU ARE WAIVING HEALTH BENEF	TITS)		
☐ I waive health coverage for myself, and/or my dependents. Please indicate one of the following reas ☐ I (We) have coverage under another health care benefit plan. ☐ I (We) do not wish to enroll in		h 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 information. Wellmark maintains the confidentiality of <u>all</u> information received and it will not be released to any person or facitly. 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 live or prerecorded calls. I give Wellmark permission to use my personal data (including personally identifiable information)

# J. AUTHORIZATION AND CERTIFICATION (IF ENROLLING IN IOWA CHOICE OR NATIONAL CHOICE), cont'd

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		_/		