Wellmark®

Wellmark Blue Cross Blue Shield of Iowa
Wellmark Health Plan of Iowa, Inc.

Independent Licensees of the Blue Cross and Blue Shield Association

PO Box 9232
Des Moines, Iowa 50306-9232

State of Iowa Indemnity, PPO, and Blue Access® Group Application

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

☐ New Hire ☐ Late Enrollee ☐ Special Enrollee ☐ Change

A. NAME, ADDRESS AND COVERAGE

Name (Last) (First)	Telephone No. ( )	Social Security No. (Required)
Residence (No.) (Street Or Rfd No.) (City) (State) (Zip)	Status ☐ Single ☐ Married ☐ Common Law (Notarized Affidavit Required) ☐ Domestic Partner (Notarized Affidavit Required)	Birthdate _____/_____/_____

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

Type Of Benefits Desired ▶	☐ Program 3 Plus ☐ Iowa Select ☐ Deductible 3 Plus ☐ Blue Access®	Medicare Part A Effective Date: _____/_____/_____
	Coverage Does Not Start Until An Effective Date Is Assigned	Medicare Part B Effective Date: _____/_____/_____

B. CONTRACT INFORMATION

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

	Name (First) (Last)	Birthdate Mm/Dd/Yy	Gender	Social Security Number (Must Complete)	MUST COMPLETE IF APPLICABLE: 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 Children Here If Family Contract	(Child)	_____/_____/_____	☐ Male ☐ Female		☐ Student ☐ Disabled	☐ Yes ☐ No	☐ Yes ☐ No
	(Child)	_____/_____/_____	☐ Male ☐ Female		☐ Student ☐ Disabled	☐ Yes ☐ No	☐ Yes ☐ No
	(Child)	_____/_____/_____	☐ 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

Spouse or Domestic Partner Name (as it appears on Medicare card): _____ Medicare ID (HIC) No.: _____	Effective Date (Part A): _____/_____/_____ Effective Date (Part B): _____/_____/_____	Dependent Name (as it appears on Medicare card): _____ Medicare ID (HIC) No.: _____	Effective Date (Part A): _____/_____/_____ Effective Date (Part B): _____/_____/_____

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 No.: _____

Policyholder Name (First, Last): _____

Employer (if applicable): _____

Insurance Company/HMO Name and Address: _____

Who is covered by the other health plan?
☐ Self ☐ Spouse or Domestic Partner
☐ Children
Effective Date: _____/_____/_____

F. PRIOR COVERAGE INFORMATION

☐ Yes ☐ No New Hire: Did you, your spouse or domestic partner, or 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 Ins. Co.: _____ Policy No.: _____

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

G. AUTHORIZATION AND CERTIFICATION

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.

Employee Signature _____ Date _____/_____/_____

H. 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 the back of this application.

I. 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.

J. 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 making 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 authorize my employer, as my agent, to deduct from my pay or collect from me in advance the monthly rates therefore and remit such sums to Wellmark on my behalf. This authorization is to remain in effect until Wellmark is notified by me or my employer to the contrary. 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.