Wellmark Health Plan of Iowa

Large Group Application

State of Iowa

BlueAdvantage®

M-5716 11/12

State of Iowa Application for Health Insurance

☐ **New Application** ☐ **Change**	**Health Plan** Blue Advantage®
Group/Section No.	Effective Date _____/_____/_____

A. Employee Information

☐ New Hire ☐ Late Enrollee ☐ Special Enrollee ☐ Change

Name (First, Last)	Social Security Number (Required)	☐ Male ☐ Female	Birthdate _____/_____/_____
Address (Include Street, Building Name/No., Apt. No., City, State, Zip)	Telephone ( )	Status ☐ Single ☐ Married ☐ Common Law (Notarized Affidavit Required) ☐ Domestic Partner (Notarized Affidavit Required)	
☐ Full-Time ☐ Part-Time ☐ Retiree ☐ COBRA	Disabled? ☐ Yes ☐ No	Medicare Enrolled? ☐ Yes ☐ No	Hire Date _____/_____/_____
Full Name of Primary Care Provider (Doctor)			Is this a new provider for you? ☐ Yes ☐ No
Address of Primary Care Provider (Doctor) Street, Building Name/No. _____ City _____ State _____ Zip _____			Full Name of OB-GYN (optional)

B. Event(s) or Reason(s) for changing Contract

☐ Marriage ☐ Death ☐ Divorce ☐ Birth/Adoption ☐ Change of Spouse's or Domestic Partner's Employment ☐ Other: _____

Name of Affected Party: _____ Explanation: _____ Date of Event: _____/_____/_____

C. Medicare Coverage

Employee Name (as it appears on Medicare card):	Medicare ID (HIC) No.:
Effective Date (Part A): _____/_____/_____	Effective Date (Part B): _____/_____/_____
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): _____/_____/_____

Persons Covered by Medicare Elect: ☐ Medicare Prime ☐ Employer Prime to Medicare

D. Other Carrier Information

Will your, your spouse or domestic partner, or your dependents keep other health coverage in addition to this Wellmark, Inc. coverage? ☐ Yes ☐ No
If yes, please complete the following section.

Name (First, Last)		
Employer (if applicable)		
Insurance Company/HMO Name and Address		
Policy No.	Who is covered by other health plan? ☐ Self ☐ Spouse or Domestic Partner ☐ Children	Effective Date _____/_____/_____

E. Prior Coverage Information

Did you have health coverage in the last three months? ☐ Yes ☐ No
If yes, please complete the following section.

Name (First, Last)		
Employer (if applicable)		
Insurance Company/HMO Name and Address		
Policy No.	List Covered Persons	Effective Date _____/_____/_____ End Date _____/_____/_____

F. Spouse or Domestic Partner Information (This information is needed only if a spouse or domestic partner is to be covered under this policy.)

Spouse or Domestic Partner	Gender ☐ M ☐ F	Social Security Number (Required)	Birthdate _____/_____/_____	Disabled ☐ Y ☐ N	Medicare Enrolled ☐ Y ☐ N
Full Name of Primary Care Provider (Doctor)				Is this a new provider for you? ☐ Y ☐ N	
Complete Address of Primary Care Provider (Doctor)		Full Name of OB-GYN (optional)			

Social Security Number	Group/Billing Unit No.	Effective Date
		_____/_____/_____

G. Dependent Information (This information is needed only if a dependent is to be covered under this policy.)

Dependent	Gender	Social Security Number	Birthdate	Out of Area	Full-time Student	Disabled	Medicare Enrolled
	☐M ☐F		_____/_____/_____	☐Y ☐N	☐Y ☐N	☐Y ☐N	☐Y ☐N

Full Name of the Primary Care Provider (Doctor)	Is this a new provider for you? ☐Y ☐N

Complete Address of Primary Care Provider (Doctor)	Full Name of OB-GYN (optional)

Dependent	Gender	Social Security Number	Birthdate	Out of Area	Full-time Student	Disabled	Medicare Enrolled
	☐M ☐F		_____/_____/_____	☐Y ☐N	☐Y ☐N	☐Y ☐N	☐Y ☐N

Full Name of the Primary Care Provider (Doctor)	Is this a new provider for you? ☐Y ☐N

Complete Address of Primary Care Provider (Doctor)	Full Name of OB-GYN (optional)

Dependent	Gender	Social Security Number	Birthdate	Out of Area	Full-time Student	Disabled	Medicare Enrolled
	☐M ☐F		_____/_____/_____	☐Y ☐N	☐Y ☐N	☐Y ☐N	☐Y ☐N

Full Name of the Primary Care Provider (Doctor)	Is this a new provider for you? ☐Y ☐N

Complete Address of Primary Care Provider (Doctor)	Full Name of OB-GYN (optional)

H. Authorization and Certification

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 ______/______/______

I. Waiver of Enrollment (Please complete if you are waiving health or life benefits.)

☐ I waive health coverage for my dependents and myself. Please indicate reason:

☐ I (We) have coverage under another health care benefit plan. ☐ I (We) do not wish to enroll in the health plan.

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

K. 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 Health Plan of Iowa, Inc. (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 to 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 and mental health 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.