



PO Box 9232
Des Moines, Iowa 50306-9232

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

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

STATE POLICE
OFFICERS COUNCIL
GROUP APPLICATION

Independent Licensees of the Blue Cross and
Blue Shield Association

New Hire Late Enrollee Special Enrollee Change

A. NAME, ADDRESS AND COVERAGE
Form section for personal and contact information, including name, address, telephone, social security, and insurance details.

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

Table with columns for Name, Birthdate, Gender, Social Security Number, Student Or Disabled, Soc. Sec. Disabled?, and Medicare Enrolled? for family members.

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

Form section for reporting events such as marriage, birth/adoption, death, divorce, or change of spouse's employment.

D. MEDICARE COVERAGE

Form section for Medicare coverage details, including spouse/partner name, effective dates, and Medicare ID numbers.

E. OTHER CARRIER INFORMATION

Form section for other health carrier information, including policy numbers, names, and coverage details.

F. PRIOR COVERAGE INFORMATION

Form section for prior coverage information, including questions about health coverage 63 days prior to hire or enrollment.

G. AUTHORIZATION AND CERTIFICATION

Form section for authorization and certification, including a statement of understanding and a signature line.

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

Form section for waiver of enrollment, including reasons for waiving health coverage and a reference to the back of the 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.