Wellmark® Iowa

An Independent Licensee of the Blue Cross and Blue Shield Association

Application for MedicareBlue Supplement℠

A. Membership Information

FB Member # (if applicable)	FB County # (if applicable)	Policy Effective Date ______/______/______
Applicant Name *(First, Middle, Last)*		Social Security No.
Date of Birth: _______/_______/_______		Gender ☐ Male ☐ Female
Daytime Phone ( )	E-mail Address (optional)	

Mailing Address (Include Street, Bldg Name/No., Apt. No.)	PO Box	City	State	Zip
Payer's Billing Information (if different from Applicant)	Payer Name:			
Payer's Mailing Address (StreetBldg Name/No., Apt. No.)	PO Box	City	State	Zip

☐ Yes ☐ No	Have you used tobacco during the 12 months immediately preceding the effective date of this application? **Note:** You do not need to answer this question if you are applying during the six-month open enrollment period which begins the month you first became **both** 65 or older **and** were enrolled in Medicare Part B.
☐ Yes ☐ No	Is this application for reinstatement of a policy which was suspended?

B. Medicare Information (As shown on your Medicare ID Card)

1. Health Insurance Claim No. (Medicare ID No.): ☐☐☐☐☐☐☐☐☐☐☐ ☐ Alpha Letter
2. Hospital Insurance (Part A) Effective Date: (month/day/year) ________/________/________
3. Medical Insurance (Part B) Effective Date: (month/day/year) ________/________/________

C. Other Insurance Information

If you lost or are losing other health insurance coverage and received a notice from your prior insurer saying that you were eligible for guaranteed issue of a Medicare supplement insurance policy, or that you had certain rights to buy such a policy, you may be guaranteed acceptance in one or more of our Medicare supplement plans. Please include a copy of the notice from your prior insurer with your application. PLEASE ANSWER ALL QUESTIONS.

(Answer questions below by marking YES or NO below with an "X".) To the best of your knowledge:

☐ Yes ☐ No ☐ Yes ☐ No	1. (a) Did you turn age 65 in the last 6 months? (b) Did you enroll in Medicare Part B in the last 6 months? (c) If yes, what is the effective date? _______/_______/_______
☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No	2. (a) Are you covered for medical assistance through the state Medicaid program? (NOTE TO APPLICANT: If you are participating in a "spend-down program" and have not met your "share of cost," please answer NO to this question.) If yes, (b) Will Medicaid pay your premiums for this Medicare supplement policy? (c) Do you receive any benefits from Medicaid OTHER THAN payments toward your Medicare part B premium?
	3. (a) If you had coverage from any Medicare plan other than original Medicare within the past 63 days (for example, a Medicare Advantage plan, or a Medicare HMO or PPO), fill in your start and end dates below. If you are still covered under this plan, leave "END" blank. START _____/_____/_____ END _____/_____/_____

Applicant Name (First, Middle, Last)	Social Security Number

C. Other Insurance Information, cont'd.

☐ Yes ☐ No — 3. (b) If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare supplement policy? If yes, please complete "Notice to Applicant Regarding Replacement of Medicare Supplement Insurance or Medicare Advantage."

☐ Yes ☐ No — (c) Was this your first time in this type of Medicare plan?

☐ Yes ☐ No — (d) Did you drop a Medicare supplement policy to enroll in the Medicare plan?

☐ Yes ☐ No — 4. (a) Do you have another Medicare supplement policy in force?

(b) If so, with what company, and what plan do you have?

____

☐ Yes ☐ No — (c) If so, do you intend to replace your current Medicare supplement policy with this policy? If yes, please complete "Notice to Applicant Regarding Replacement of Medicare Supplement Insurance or Medicare Advantage."

(d) If so, what is the paid-to or expiration date of your policy: _____/_____/_____

☐ Yes ☐ No — 5. (a) Have you had coverage under any other health insurance within the past 63 days? (For example, an employer, union, or individual plan)

(b) If so, with what company and what kind of policy?

____

____

____

(c) What are your dates of coverage under the other policy?

START _____/_____/_____ END _____/_____/_____

(If you are still covered under the other policy, leave "END" blank.)

6. <u>**Agents Only**</u>: List all policies you have sold to the applicant in the last five years, including those no longer in force.

Company	Policy Number	Type of Policy	In Force? (Y/N)

D. Health Questions

You do not need to complete these health questions if you are applying for Plan A or if you are applying during the six-month open enrollment period which begins the month you first became **both** 65 or older **and** were enrolled in Medicare Part B.

☐ Yes ☐ No — **1. Within the last two years, have you received medical advice or prescription drugs for liver problems, internal cancer, stroke, Amyotrophic Lateral Sclerosis (ALS), Multiple Sclerosis (MS)?**

☐ Yes ☐ No — **2. Within the last two years, have you had or received medical advice or testing in preparation for heart surgery, bypass surgery, angioplasty, or implanting a pacemaker or defibrillator (not including updates to existing pacemakers)?**

☐ Yes ☐ No — **3. Have you received medical treatment or prescription drugs for Acquired Immune Deficiency Syndrome (AIDS) or AIDS-Related Complex (ARC) and/or tested HIV positive?**

☐ Yes ☐ No — **4. Do you currently use bottled oxygen or an oxygen concentrator to help you breathe (not including the use of a CPAP machine if you do not require oxygen) or require dialysis for kidney disease?**

NOTE: If you are not applying during the six-month open enrollment period and answer "Yes" to questions 1, 2, 3, or 4, you are only eligible to apply for Plan A.

E. Contract Information

Check the MedicareBlue Supplement Plan for which you are applying:

☐ Plan A ☐ Plan D ☐ Plan F ☐ Plan F, High Deductible ☐ Plan N

Applicant Name (First, Middle, Last)	Social Security Number

F. Payment Information

How do you want to pay for your health premiums?
Note: All billing periods are based on a calendar year.

Please do not send payment with this application. If paying by automatic withdrawal from checking include a voided check.

☐ **1. Direct Bill.**
If so, on what basis? ☐ Quarterly ☐ Semi-annually ☐ Annually

☐ **2. Use billing information on file with Wellmark.** (Available only for those with current Wellmark individual coverage.)

☐ **3. Automatic Account Withdrawal from Applicant's account.**

☐ **4. Automatic Account Withdrawal from account other than Applicant's.**

If you checked 3 or 4, please complete the following:

On what basis? ☐ Monthly ☐ Quarterly ☐ Semi-annually ☐ Annually

Date of withdrawal: ☐ 1st of the month ☐ 5th of the month

From: ☐ Checking *(Attach voided check.)*
☐ Savings *(Please complete form M-5779.)*

If Direct bill is ***not*** selected:
As the Bank Account Holder, I hereby authorize Wellmark to make automatic withdrawals from the account shown on the attached voided check in 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 adjustments when provided to the Applicant shall constitute notice to the undersigned of any such adjustment. I hereby certify that I have read and understand the provisions of the Application Agreement and Certification section. This authorization shall supersede and replace any previous authorization given by me for automatic premium withdrawal.

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 notification at least 20 days before your scheduled withdrawal.

Statements

1. You do not need more than one Medicare supplement policy.
2. If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverages.
3. You may be eligible for benefits under Medicaid and may not need a Medicare supplement policy.
4. If, after purchasing this policy, you become eligible for Medicaid, the benefits and premiums under your Medicare supplement policy can be suspended, if requested, during your entitlement to benefits under Medicaid for 24 months. You must request this suspension within 90 days of becoming eligible for Medicaid. If you are no longer entitled to Medicaid, your suspended Medicare supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstated if requested within 90 days of losing your Medicaid eligibility. If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstated policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.
5. If you are eligible for, and have enrolled in a Medicare supplement policy by reason of disability and you later become covered by an employer or union-based group health plan, the benefits and premiums under your Medicare supplement policy can be suspended, if requested, while you are covered under the employer or union-based group health plan. If you suspend your Medicare supplement policy under these circumstances, and later lose your employer or union-based group health plan, your suspended Medicare supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstated if requested within 90 days of losing your employer or union-based group health plan. If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstated policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.
6. Counseling services may be available in your state to provide advice concerning your purchase of Medicare supplement insurance and concerning medical assistance through the state Medicaid program, including benefits as a Qualified Medicare Beneficiary (QMB) and a Specified Low-Income Medicare Beneficiary (SLMB).

Application Agreement and Certification

My signature on this application verifies that I have received the "MedicareBlue Supplement Outline of Coverage," the "Guide to Health Insurance for People with Medicare," and a completed copy of this application. My signature also verifies that I have read and understand the "Statements" section that appears above.

My signature verifies that, to the best of my knowledge and belief, I have answered the questions on this

Applicant Name (First, Middle, Last)	Social Security Number

Application Agreement and Certification, cont'd

application truthfully and completely. I understand that my coverage will not begin until Wellmark Blue Cross and Blue Shield of Iowa receives and accepts this application and applicable payment and assigns an effective date of coverage. If I answered "No" to the tobacco question on this application, I am eligible for a special tobacco non-user rate. If this status changes, I must notify Wellmark immediately. Wellmark may require me to recertify this status in the future.

My signature further verifies that I understand Iowa law prohibits knowingly selling more than one Medicare supplement policy to an individual. I certify that if I currently have a Medicare supplement policy in force, I will cancel my current Medicare supplement policy upon notification of acceptance for coverage by Wellmark Blue Cross and Blue Shield of Iowa. I can request that a Wellmark Blue Cross and Blue Shield of Iowa representative review my existing policies and advise whether this MedicareBlue Supplement policy will duplicate the benefits of my existing health insurance policies by calling (800) 336-0505.

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.

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 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.

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), my age, changes in tobacco user status, or other factors that require adjustments to the total premium. These changes may occur at times other than an annual or other policy 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 withdrawals 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.

Acknowledgement

I have read and understand the "Statements" and "Application Agreement and Certification" sections on this application. If I am replacing my current coverage, I have completed "Notice to Applicant Regarding Replacement of Medicare Supplement Insurance or Medicare Advantage." I hereby confirm the authority of Wellmark to make automatic withdrawals from my deposit account as set forth above under "Payment Arrangement" and that this authorization supersedes and replaces any previous authorization given by me with respect to such authority. I understand that any payment will be deposited immediately upon Wellmark's receipt of this application.

Wellmark Blue Cross and Blue Shield of Iowa
PO Box 14527
Des Moines, Iowa 50306-3527

Fax: 515-376-9045
E-mail: INDMEMMAIN@wellmark.com

Applicant's Signature X________________________ Date ____/____/____

(If POA, submit copy of legal authorization)

Agent Name ________________________ Signature ________________________

(Please Print)

Agent No. |__|__|__|__|__|__|__|__|