



Wellmark®
BlueCross
BlueShield
of Iowa

An Independent Licensee of the Blue Cross and Blue Shield Association

P. O. Box 9349 • Des Moines, Iowa 50306-9349

Application For Short Term Major Medical Expense Policy

FB Membership No. and FB County No., if applicable

Group/Billing Unit

County #

ELIGIBILITY CHECKLIST: If you answer "yes" to any of the following eligibility questions, a policy cannot be issued.

1. Is any person to be covered younger than 15 days old? No Yes
2. Will you, or any person to be covered, become eligible for Medicare or Medicaid during the policy term? No Yes
3. Within the last five years, have you or any person to be covered:
 - a. been treated, diagnosed, or been advised to seek treatment for: heart or circulatory system disorder including hypertension, and high blood pressure; stroke; diabetes, cancer or tumor; alcohol abuse; drug abuse or chemical dependency? No Yes
 - b. been treated for or diagnosed with an immune system disorder including acquired immune deficiency (AIDS) or AIDS Related Complex (ARC) and/or tested HIV positive? No Yes
 - c. been declined for health insurance due to health reasons? No Yes
4. Are you, your spouse or any dependent now pregnant? No Yes
5. Do you or anyone else listed on this application currently have hospital and/or medical coverage through Wellmark Blue Cross and Blue Shield of Iowa, or any other company, that will not terminate prior to the effective date? No Yes

MEMBERSHIP INFORMATION

| | | | | | | | |
|--|----|------|--------------|------------------------|--|--|--|
| NAME OF PRIMARY APPLICANT (FIRST, MIDDLE, LAST) | | | | SOCIAL SECURITY NO. | | BIRTHDATE / / | |
| ADDRESS (INCLUDE STREET, BUILDING NAME/NO., APT. NO., CITY, STATE, ZIP) | | | | HOME PHONE () | | SEX <input type="checkbox"/> M <input type="checkbox"/> F | |
| Are you a resident of Iowa? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | MARITAL STATUS <input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED <input type="checkbox"/> COMMON LAW | |
| List all other individuals to be covered, in addition to primary applicant. | | | | BIRTHDATE M / D / Y | | SOCIAL SECURITY NO. | |
| First | MI | Last | Relationship | | | SEX <input type="checkbox"/> M <input type="checkbox"/> F | |
| | | | | / / | | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| | | | | / / | | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| | | | | / / | | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| | | | | / / | | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| | | | | / / | | <input type="checkbox"/> Yes <input type="checkbox"/> No | |

POLICY TYPE INFORMATION

*The effective date cannot be prior to or the same date as the date you sign this application.

| | | |
|--|---|---|
| THIS REQUEST FOR COVERAGE IS FOR: <input type="checkbox"/> SINGLE <input type="checkbox"/> TWO-PERSON <input type="checkbox"/> FAMILY | POLICY TERM MUST BE 30 DAYS AND NOT TO EXCEED 6 MONTHS Effective Date* _____ Termination Date _____ | DEDUCTIBLE/OUT-OF-POCKET MAXIMUM <input type="checkbox"/> \$ 250 / \$1,000 <input type="checkbox"/> \$ 500 / \$1,500 <input type="checkbox"/> \$ 1,000 / \$3,000 |
|--|---|---|

| | | | |
|--|------------------------|------------------------|----------------|
| Primary Applicant Name (First, Middle, Last) | Social Security Number | Group/Billing Unit No. | Effective Date |
|--|------------------------|------------------------|----------------|

PAYMENT INFORMATION

- CHECK ENCLOSED FOR ENTIRE POLICY TERM
- MONTHLY AUTOMATIC ACCOUNT WITHDRAWAL* (available only for policy durations of 3 months or more)
- WITHDRAWAL ON 1ST OF THE MONTH
- WITHDRAWAL ON 5TH OF THE MONTH

*ADD \$10.00 PER MONTH TO THE MONTHLY PREMIUM AMOUNT, INCLUDING THE FIRST MONTH, IF USING THIS METHOD. FOR MONTHLY AUTOMATIC BANK PAYMENTS, YOUR POLICY MUST END ON THE FIRST DAY OF THE MONTH AND THE POLICY TERM CANNOT EXCEED 6 MONTHS OF COVERAGE.

DO YOU WANT IT DEDUCTED FROM: SAVINGS CHECKING--ATTACH A VOIDED CHECK

IF SOMEONE OTHER THAN PRIMARY APPLICANT IS PAYING THROUGH AUTOMATIC BANK WITHDRAWAL, PLEASE COMPLETE FORM M-5750 AUTHORIZATION FOR AUTOMATIC WITHDRAWAL.

| | | | |
|-------------------|--|--|---|
| PREMIUM SUBMITTED | | | <input type="checkbox"/> 1 ST ISSUANCE |
| \$ | | | <input type="checkbox"/> 2 ND ISSUANCE |

EMPLOYER CONTRIBUTIONS

Will your employer be paying any part of the premium for this certificate either directly or through wage adjustments or other means of reimbursement? No Yes If yes, check one item below:

Applicant is owner of a sole proprietor business Employer is deducting the full premium from employee's payroll Employee is part-time or temporary and not eligible for small employer coverage

Employer has only one eligible employee

Employer has been denied the opportunity to purchase insurance due to low participation/contribution (attach copy of denial)

Will your premium payments for this coverage be deductible on your federal income tax return as a trade or business expense other than the special health insurance deduction available to self-employed persons? No Yes

AGREEMENT AND CERTIFICATION

I certify that I am legally authorized to apply for coverage for myself and for all other persons named in this application. I understand that I am making application for the coverage offered by Wellmark, Inc., doing business as Wellmark Blue Cross and Blue Shield of Iowa (Wellmark), and that coverage will not start on the requested effective date until after this application and the premium submitted are received and accepted by Wellmark and the requested effective date is approved by Wellmark.

I certify that, after this application was completed, I carefully and fully read it, that the statement 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 upon 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 have concealed any material fact, Wellmark will be entitled to declare the health care policy void and to refuse allowance of benefits to any person thereunder.

I understand that the coverage applied for will not pay benefits for any expense incurred for any pre-existing condition. I understand that this is not a continuation of any previous coverage, including any prior Wellmark Blue Cross and Blue Shield of Iowa Short Term Major Medical policy.

I acknowledge that this policy does not meet the definition of qualifying previous coverage or qualifying existing coverage is defined in section 513C.3(15)(a), (b), or (c).

I acknowledge receipt of a copy of this application, an outline of coverage, and a benefits policy.

APPLICANT SIGNATURE

DATE

AGENT SIGNATURE

DATE

PRINT AGENT NAME

AGENT NO.