Wellmark® Iowa

An Independent Licensee of the Blue Cross and Blue Shield Association

Individual Health Plan Contract Change Form

Instructions: Use a ballpoint pen to complete the form and follow guidelines listed below:

GUIDELINES

Complete checked section if you are using this form to:	A	B	C	D	E	F	J
Remove the Policyholder	✓	✓	✓	✓	✓*	✓	✓
Add a member to current coverage. (Does not apply to Pool 5. Use N-53254.)	✓	✓		✓	✓*	✓	✓
Remove a member	✓	✓			✓*	✓	✓
Remove a member and member moving to new policy	✓	✓	✓	✓	✓*	✓	✓
Change to a different plan option to decrease level of benefits	✓				✓	✓	✓
Change billing option	✓					✓	✓

*Complete if changing plan option.

NOTE:

- Existing benefits will remain in place unless you complete section E. Plan Changes.
- Complete a medically underwritten application (N-53254) if you are increasing your level of benefits (moving to a lower deductible amount within the same plan option, moving to a plan option that has a higher level of benefits).
- If you currently have a Pool 5 plan option, complete a medically underwritten application (N-53254) if you are:
  - Adding an eligible individual to current coverage due to an event.
  - Adding an eligible individual age 19 and over to current coverage other than at time of event.
  - Adding an eligible individual age 18 and under to current coverage during Open Enrollment.
- If adding a dependent age 18 and under to Pools 1 through 4 and request is made beyond the allowed time to be added due to an event, the dependent may be added only at Open Enrollment.

A. EXISTING POLICYHOLDER INFORMATION (REQUIRED)

Existing Policyholder Name *(First, Middle, Last)*	Social Security Number

Please check box to left of item(s) you are changing and provide complete information.

B. CONTRACT CHANGES

☐ **Removing Policyholder:** ☐ Death ☐ Medicare Eligible ☐ Obtain Employer Group Coverage

If obtaining employer group coverage: List group name __________________ List carrier name ______________________

(Attach documentation from Employer that dependents are not eligible for Employer coverage.)

List date of event: ______/_______/______

☐ **Use only when adding members to Pools 1, 2, 3, and 4 plan options.**

Adding Member: ☐ Appointment as Legal Guardian (Provide legal documentation) ☐ Adoption or Placement for Adoption ☐ Birth

☐ Care of a Foster Child ☐ Dependent child previously covered under this policy resumes full-time student status ☐ Marriage

List date of event: ______/______/______ List requested effective date: ____/____/____*. (Must be first day of the month.)

*If you do not provide a requested effective date, your effective date will be assigned based on Section G: Effective Dates.

☐ **Removing Member:** ☐ Active Military Duty Service ☐ Completion of full-time schooling of a dependent child age 26 or older ☐ Death

☐ Dependent Child reaches age 26 and is not a full-time student or permanently disabled ☐ Divorce/Annulment/Legal Separation

☐ Marriage of a dependent child age 26 or older ☐ Spouse Obtains Employer Group Coverage ☐ Other, Specify __________________

List date of event: ______/______/_____ List name(s) of member(s) removed: ____

If removing a member without an event, your cancellation date will be the first of the month following your signature date on the change form.

C. NEW POLICYHOLDER INFORMATION

New Policyholder Name *(First Middle, Last)*			Social Security Number		Requested Effective Date	
					/ /	
Mailing Address Street	Bldg. Name/No., Apt. No.	PO Box	City		State	Zip
Billing Address (if different from Mailing Address) Street	Bldg. Name/No., Apt. No.	PO Box	City		State	Zip
Telephone Number ( )	E-mail Address					

Existing Policyholder Name *(First, Middle, Last)*	Social Security #

D. MEMBERS ADDED TO EXISTING CONTRACT OR MEMBERS MOVED TO NEW CONTRACT

☐

Name (First, MI, Last)	Relationship	Birthdate	Social Security Number	Gender	Full-time Student?	Disabled?*	Tobacco User?**
Applicant	Self			☐ M ☐ F	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Spouse	Spouse			☐ M ☐ F	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Dependent				☐ M ☐ F	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Dependent				☐ M ☐ F	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

*Is disabled person(s) eligible for Medicare? ☐ Yes ☐ No
**Answer yes if the person listed has used tobacco during the 12 months immediately preceding the date of this application.

E. PLAN CHANGES

☐ Please change my current grandfathered plan option to a non-grandfathered plan option with the same deductible.
- Select first of the month effective date:___/___/___ (Your earliest effective date will be the first of the month following signature date.)

☐ Complete this section to decrease your level of benefits (i.e., increasing your deductible within the same plan option, moving to a plan option that has lesser benefits) within your existing selected plan option. You must be a resident of Iowa to change your deductible amount.
- Select your new plan option by placing a check mark in the box prior to plan deductible level.
- Select first of the month effective date:___/___/___ (Your earliest effective date will be the first of the month following signature date.)

Current Plan Options (Current Products Available for New Sales - Pool 5)

Alliance Select℠ Comprehensive	Alliance Select℠ Enhanced	Alliance Select℠ Value	Blue Basics	Blue Priority℠ HSA
☐500 ☐1000 ☐1500 ☐3000 ☐4500	☐750 ☐1250 ☐1850 ☐2500 ☐5500 ☐9500	☐2000 ☐5000	☐3000 ☐5000	☐1700A ☐1700B ☐2750A ☐2750B ☐5400A ☐ Maternity ($2500 Deductible)

Please indicate "Yes" or "No" for each of the following Wellmark optional benefits. If you do not answer "Yes" or "No" for each optional benefit, Wellmark will assign optional benefits as covered in existing policy. **Blue Dental** ☐Yes ☐No **Supplemental Accident** ☐Yes ☐No **Contraceptives** ☐Yes ☐No
(Not available with Blue Basics and HSA products)

Blue Transitions Plan Options

☐ Alliance Select Transitions 1500 ☐ Alliance Select Transitions 2500 ☐ Blue Priority HSA/Alliance Select Transitions 5400

2001 to 2007 Plan Options (Existing Products No longer Offered for New Sales - Pool 4)

Alliance Select℠ Comprehensive	Alliance Select℠ Enhanced	Alliance Select℠ Essential	HSA	Classic Blue®
☐300 ☐750 ☐1250 ☐1750	☐600 ☐1200 ☐1800 ☐2400 ☐3000 ☐4200	☐1500 ☐2500	☐1550 ☐2550	☐3000 ☐5000

Please indicate "Yes" or "No" for each of the following Wellmark optional benefits. If you do not answer "Yes" or "No" for each optional benefit, Wellmark will assign optional benefits as covered in existing policy. **Blue Dental** ☐Yes ☐No **Supplemental Accident** ☐Yes ☐No **Contraceptives** ☐Yes ☐No
(Not available with HSA products)

1996 to 2001 Plan Options (Existing Products No Longer Offered for New Sales - Pool 3)

Alliance Select							Classic Blue				
☐Plan I	☐Plan II	☐Plan III	☐Plan III - A	☐ Plan IV	☐Plan V	☐Plan V - A	☐Plan VI	☐Plan VII	☐Plan VIII	☐Plan IX	☐Plan X

Please indicate "Yes" or "No" for each of the following Wellmark optional benefits. If you do not answer "Yes" or "No" for each optional benefit, Wellmark will assign optional benefits as covered in existing policy. **Contraceptives** ☐Yes ☐No **Supplemental Accident** ☐Yes ☐No

Prior to 1996 Plan Options (Existing Products No Longer Offered for New Sales - Pools 1 and 2)

☐Plan I ☐Plan II ☐Plan III ☐ Plan IV ☐Plan V ☐2500

Please indicate "Yes" or "No" to the following Wellmark optional benefit. If you do not answer "Yes" or "No", Wellmark will assign the optional benefit as covered in existing policy. **Supplemental Accident?** ☐Yes ☐No

Existing Policyholder Name *(First, Middle, Last)*	Social Security #

F. BILLING INFORMATION - Complete if new policyholder, changing billing option or selecting "Use Billing information on file with Wellmark".

☐ How do you want to pay for health premiums and service fees?

Note: All billing periods are based on a calendar year.

Please do not send payment with this form.
IF PAYING BY AUTOMATIC WITHDRAWAL FROM CHECKING, INCLUDE A VOIDED CHECK.

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

☐ 2. **Use billing information on file with Wellmark.** (Available only for those with existing 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:

If so, on what basis? ☐ Monthly ☐ Quarterly ☐ Semi-annually ☐ Annually

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

From: ☐ Checking *(Attach a voided check)*

☐ Savings *(If you want to have premiums and service fees withdrawn from your savings account, please complete form M-5779.)*

If Direct Bill is *not* selected:

I hereby certify that I have read and understand the section below entitled "Authorization and Certification," and agree to the terms regarding automatic premium withdrawals as described therein. As the Bank Account Holder, I authorize Wellmark to make automatic withdrawals from the account shown on the attached voided check in the amount of the premium and service fees. I understand and agree that notices of any premium and service fee adjustments provided to the Policyholder shall constitute notice to the undersigned of any such adjustment. This authorization supersedes and replaces any previous authorization given by me for automatic premium withdrawal.

Bank Account Holder's Signature (if other than Policyholder): ____________________ **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.

G. Effective Dates

When adding members, effective dates will be:

Event:	Effective Date:
Birth	First day of the month of the birth or first day of the month following birth
Adoption/Placement for Adoption	First day of the month in which physical custody takes place; if physical custody within 60 days of birth, first day of the month of the birth
Appointment as Legal Guardian	First day of the month in which the court makes the appointment
Care of Foster Child	First day of the month in which the child enters home
Dependent resumes full-time student status	First day of the month the event occurs or first of the month following event
Marriage	First day of the month following marriage; or, if the application is signed before the first day of the month of the marriage, the effective date is the first day of the month of the marriage.

H. Adding and Removing Member Due to an Event

Adding Members. The following events allow you to add the person directly affected by the event:

Appointment as a Legal Guardian of a child.
Birth, Adoption, or Placement for Adoption.
Care of a Foster Child (when placed in your home by an approved agency).
Dependent child previously covered under this policy resumes full-time student status.
Marriage, which permits addition of the new spouse and the new spouse's children.

To add a newborn or a child newly adopted or placed for adoption to your coverage, you must notify us within 60 days. For other events that allow adding members, you must submit your request within 31 days of the date of the event to ensure that the new person age 19 and older will not be denied.

If you do not submit your request within 31 days of the event, the person age 19 and older to be added may be declined coverage. Dependents age 18 and under not added within the event time period may be added only at Open Enrollment.

If you have a Pool 5 plan option, complete an application (N-53254) to add a member. For dependents age 18 and under, medical underwriting will apply to determine appropriate rates. If you have a Pool 1 through 4 plan option and do not submit your request for adding the new person age 19 and over within 31 days, complete an application (N-53254).

Removing Members. The following events require you to remove the affected family member from your coverage:

- **Active Military Service.**
- **Death.**
- **Divorce, Annulment, or Legal Separation.**

In case of the following coverage removal events, the affected dependent child's coverage may be continued until the next policy anniversary date on or after the date of the event:

- **Completion of Full-time Schooling** of a dependent child if the child is age 26 or older.
- **Dependent Child** who is not a full-time student or permanently disabled reaches age 26.
- **Marriage** of a dependent child age 26 or older.

For purposes of this provision, the *policy anniversary date* is the first day of the month each year in which the plan member was originally enrolled in Wellmark individual health coverage.

You must notify us within 31 days of the date of an event that changes the coverage status of a member covered under this policy. If you fail to provide notification of an event that requires you to remove a member, your coverage under this policy may terminate.

Existing Policyholder Name *(First, Middle, Last)*	Social Security #

I. Authorization and Certification

I certify that I have carefully and fully read the Authorization and Certification language appearing below.

I certify that I am legally authorized to make changes in coverage for myself and on behalf of all other persons named on my current policy and in this form, and I further have confirmed with all persons named on my current policy and on this form that my signature is binding to change coverage. If I have made changes in my plan selection, I understand that I am applying for coverage as indicated on this form which is underwritten by Wellmark, Inc., doing business as Wellmark Blue Cross and Blue Shield of Iowa ("Wellmark"), providing the specified individual health care and dental coverages. I further understand that coverage applied for will not start until this form and the appropriate premium and service fee payment amount, if applicable, are received and accepted by Wellmark.

The statements and answers set forth in this form are full, true, and correct. I have consulted with each other person named in this form to confirm that information about them is full, true, and correct. I understand that Wellmark will rely on the completeness and truthfulness of the information given in the statements made in this form or by telephone or in writing to Wellmark, and that, if I performed an act, practice, or omission that constitutes fraud or I have made an intentional misrepresentation of material fact in this form, Wellmark will be entitled to declare coverage applied for void and to refuse allowance of benefits to any person thereunder.

If I answered "No" to the tobacco user question for any person listed in Section D, that person is 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. If Wellmark determines within the initial two years that this status is incorrect, Wellmark will retroactively collect historical differences in premiums before claims will be paid, and will start applying the tobacco user rate on the first of the month following Wellmark's receipt of this information.

If I currently have a grandfathered health plan, I understand that making a change to my current benefits could potentially change the grandfathered status of my health care plan. If I lose the grandfathered status of my health care plan, I may be required to incorporate health care reform mandates that are required of non-grandfathered plans.

I understand and agree that the amount of my periodic premium payment and service fee, if applicable, 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), the number of covered family members, members' ages, changes in tobacco user status, or other factors that require adjustments to the total premium and service fee, if applicable. These changes may occur at times other than at 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 and service fee. 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.

I understand when adding a member(s) to a current grandfathered individual policy issued by Wellmark, any health condition amendments previously signed and in effect on an existing member will remain on the policy. If you are currently enrolled in a non-granfathered plan, or your requested change results in the issuance of a non-grandfathered plan, any health condition amendments previously signed and in effect will not be applied for individuals under age 19. For individuals over age 19 who are enrolled on a non-grandfathered plan, any health condition amendment previously signed will remain on the policy.

J. Signature

I have read and understand the Authorization and Certification language and hereby confirm the authority of Wellmark to make automatic withdrawals from my deposit account as described therein. This authorization supersedes and replaces any previous authorizations given by me for automatic premium withdrawal.

Existing Policyholder Signature X ______________________ Date ____/____/____

New Policyholder Signature X ______________________ Date ____/____/____

If applicant is a minor, please sign below.

Parent/Legal Guardian Printed Name ______________________

Parent/Legal Guardian Signature X ______________________ Date ____/____/____

If child(ren) only policy, list natural parent's (s') name(s) ______________________

Agent Signature, if applicable X______________________ Agent No. | | | | | | | | |

Wellmark must receive the completed form (pages 1 through 4) within 15 days of the signature date.

Send completed form to:
Wellmark Blue Cross and Blue Shield of Iowa
Mail Station 3W190
PO Box 14527
Des Moines, IA 50306-3527
OR
Fax to: 515-376-9045
OR
E-mail to: INDMEMMAIN@wellmark.com

Part 1 - Wellmark Blue Cross and Blue Shield of Iowa Part 2 - Agent