



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

Independent Licensees of the Blue Cross and
Blue Shield Association



Failure to fill out this application completely may result in a delay of coverage.

Group Application For Health, Dental & Life Insurance New Hire Late Enrollee Special Enrollee Change

This area completed by Employer:
Group/Billing Unit No.: _____ Department No.: _____ Effective Date: ____/____/____
Employer Name: _____ Employer Address: _____

A. Employee Information

Name (First, Last): _____ Hire Date: ____/____/____
Address: _____ Male Female
City: _____ State: _____ Zip: _____ Birthdate: ____/____/____
Telephone: (____) _____ Marital Status: Single Married
E-mail Address (optional): _____ Common Law (Notarized Affidavit Required)
Employment Status: Full-Time Part-Time Retiree COBRA Social Security Number (required): _____
Health: Self Spouse Child(ren) Health Plan Code _____ Deductible Amount _____
Blue Dental: Self Spouse Child(ren)
Dearborn National:* Self Spouse Child(ren) Disability:* Employee/Short-Term Employee/Long-Term
*Dearborn National is an independent life insurance company that does not provide Wellmark Blue Cross and Blue Shield of Iowa products or services. Dearborn National is solely responsible for the life insurance coverage.

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

Marriage Death Divorce Birth/Adoption Change of Spouse's Employment
 Other, Specify: _____ Date of Event: ____/____/____

C. Members Covered (Please indicate who you are choosing to cover.)

List Name (First, Last) of all others to be covered	Birthdate	Social Security Number REQUIRED FOR SPOUSE AGE 45 AND OLDER; PREFERRED FOR ALL OTHERS	Gender	Full-Time Student?
Spouse	/ /		<input type="checkbox"/> M <input type="checkbox"/> F	
Dependent	/ /		<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Yes
Dependent	/ /		<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Yes
Dependent	/ /		<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Yes

Employee Name (First, Last)	Social Security Number
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D. Medicare Coverage (Required.)

Yes No Are you and/or anyone listed in section C Social Security disabled?

If yes, list names _____

Yes No Are you and/or anyone listed in section C enrolled in Medicare?

If yes, complete following as appropriate:

Employee Name (as it appears on Medicare card): _____ Medicare ID (HIC) No.: _____

Effective Date (Part A): ____/____/____ Effective Date (Part B): ____/____/____

Spouse 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): ____/____/____

E. Other Carrier Information (Required.)

Yes No Will you, your spouse or your dependents keep other health coverage in addition to this Wellmark, Inc. coverage?

If yes, please complete the following:

Policyholder Name (First, Last): _____ Date of Birth: ____/____/____

Please list those covered by other health plan(s): _____

Policy No.: _____ Effective Date: ____/____/____

Employer Name (if coverage is through employer group): _____

Insurance Company/HMO Name and Address or Phone Number: _____

Yes No Is there a divorce decree/court order that requires one parent to provide health insurance coverage for any dependent? If yes, please complete the following:

List dependent(s): _____

List name of person required to provide health insurance: _____

List name of person who has primary physical custody: _____

F. Prior Coverage Information

Yes No New Hire: Did you, your spouse or dependents age 19 and over* have health coverage within 63 days prior to the hire date stated above?

Yes No Special Enrollee/Late Enrollee: Did you, your spouse or dependents age 19 and over* have health coverage within 63 days prior to the effective date of this coverage?

If yes to either question, please complete the following:

Name and Address of Ins. Co.: _____

Policy No.: _____

Covered Person(s): _____

Effective Date: ____/____/____ End Date: ____/____/____

*The Affordable Care Act (ACA) requires that no pre-existing condition exclusion be applied to individuals under 19 effective the first plan year on or after September 23, 2010 or at the start of the group's deductible benefit period.

Employee Name (First, Last)	Social Security Number
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G. Life/Disability Options (Please complete only if you checked life or disability above.)

	Date of Birth	Social Security #	Relationship	Benefit %
<input type="checkbox"/> Primary Beneficiary	/ /			
<input type="checkbox"/> Primary Beneficiary <input type="checkbox"/> Contingent Beneficiary (Please indicate if beneficiary is Primary or Contingent)	/ /			

Employee Salary: Weekly Monthly Annual \$ _____

Occupation: _____ Insurance Class: _____

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

I waive health coverage for my dependents and myself. Please indicate one of the following reasons:

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

I waive dental coverage for my dependents and myself. Please indicate one of the following reasons:

- I (We) have coverage under another dental plan.
- I (We) do not wish to enroll in the dental plan.

I waive disability coverage.

I waive life coverage.

Please see the Important Information Regarding Waiver of Enrollment section below.

I. Important Information Regarding Waiver of Enrollment

<p>If you are declining enrollment for yourself or your dependents (including your spouse) 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</p>	<p>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 3E499, Des Moines, IA 50306-9232, or call 800-524-9242.</p>
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J. Authorization and Certification

<p>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") and, when applicable, life and/or disability insurance provided by Dearborn National (collectively the "Insurers"). 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 the Insurers on my behalf. This authorization is to remain in effect until the Insurers are 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.</p>	<p>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 each Insurer and an effective date of coverage is established by the Insurers.</p> <p>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 the Insurers 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, the Insurers will be entitled to declare the contracts applied for void and to refuse</p>
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Employee Name (First, Last)	Social Security Number
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J. Authorization and Certification (cont'd.)

allowance on benefits to any person thereunder.

If the Health Plan Deductible that I have selected is combined with a Health Savings Account (HSA), I understand that enrolling in HSA coverage does not guarantee that I am or will be eligible to make contributions to an HSA or that contributions can be made to an HSA on my behalf.

If I am applying for life and/or disability insurance, I understand that if I am not actively at work on the effective date of my coverage, my life and/or disability insurance will not begin until the day I return to work. I further understand that if I have chosen to waive life and/or disability insurance and I wish to reapply at a later date, I will be required to furnish evidence of insurability satisfactory to the life insurance carrier selected by my employer or group sponsor.

I authorize any health care provider, including but not limited to; surgeon, physician, psychologist, nurse, social worker, or health care facility to release to the Insurers 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 the Insurers or 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 unless the individual is applying for life and/or disability coverage underwritten by Dearborn National in which case the application, without any further health records or Attending Physician Statements (APS) received, will be released to Dearborn National.

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 the Insurers then have the right to condition eligibility determination and enrollment on the receipt of this signed authorization.

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 ____/____/____