Wellmark

Employee Application for ACA Small Groups (1-50)

A. Employer Information

Employer Name Navigate Homes Iowa LLC Phone (319) 466-4300

Group Number 00628305-1000

Address Line 1 (Street Address or Suite#) 2303 Jones Blvd Suite B

Address Line 2 (PO Box, Street Address)

City Coralville State Iowa ZIP 52241

B. Member Elections Information

(If you need to list more than four dependents, please write all necessary information on a separate sheet of paper and attach to this application. Your employer determines eligibility for coverage, confirm with your employer that the dependent types listed below are eligible.)

Member Type	First Name	Last Name	Medical	Blue Dental	Avesis Vision[1]	Waive All Coverage
Employee			☐	☐	☐	☐
Spouse			☐	☐	☐	☐
Dependent 1			☐	☐	☐	☐
Dependent 2			☐	☐	☐	☐
Dependent 3			☐	☐	☐	☐
Dependent 4			☐	☐	☐	☐

NOTE: You may only select Blue Dental or Avesis Vision plans if your employer chooses to offer them. If your employer does not offer Blue Dental or Avesis Vision, you will not be enrolled in those plans. Talk to your employer if you have any questions.

[1]*The vision plan is provided by Avesis Vision, an independent company that does not provide Wellmark Blue Cross and Blue Shield of Iowa products or services. Avesis Vision is underwritten by Fidelity Security Life Insurance Company®, Kansas City, Missouri. Vision coverage includes a Hearing Discount Savings Plan provided by Amplifon. Amplifon is an independent company that does not provide Wellmark Blue Cross and Blue Shield of Iowa products or services.*

As a Wellmark contract holder, you will receive a Summary of Benefits and Coverage (SBC) that outlines important information about your coverage. You can also access Wellmark.com/inform to help you make the best decisions for you and your family. This site includes important information on your prescription drug coverage, like the accessibility and availability of prescription drugs, how to request a current drug list and the process for requesting an exception to the drug list. You also can find a list of participating providers and facilities and how to obtain a prior authorization. For more information, or if you have any questions, you can call the Wellmark Customer Service number located on the back of your ID card.

Please List Medical Plan Name and Network*:

Please List Dental Plan Name: Blue Dental 1500 with Orthodontia

Please List Vision Plan Name:

*If you're enrolling in an HMO/WHPI plan a Primary Care Provider (PCP) must be elected for each family member. Please visit www.myWellmark.com to select your PCP.

If you are waiving coverage for yourself or your dependent(s) (including your spouse or domestic partner), you may be able to enroll yourself or your dependent(s) in this plan if you notify Wellmark within 60 days of a qualifying event.

I understand that by waiving coverage at this time, I will not be allowed to participate unless I experience a special enrollment event or at the next open enrollment period.

Signature Date ____/____/____

To request special enrollment or obtain more information, contact Customer Service, Wellmark Blue Cross and Blue Shield of Iowa, PO Box 9232, Mail Station 3E499, Des Moines, IA 50306-9232, or call 1-800-524-9242.

Wellmark Blue Cross and Blue Shield of Iowa and Wellmark Health Plan of Iowa, Inc. are independent licensees of the Blue Cross and Blue Shield Association

C. Enrollment Reason or Event

Enrollment Reason: ☐ Open Enrollment ☐ Newly Eligible ☐ Special Enrollment (If you check this option, complete the following)

Special Enrollment Event Reason:

☐ Birth/adoption or placement for adoption
☐ Marriage
☐ Divorce
☐ Foster child placement
☐ Other_____
☐ Involuntary loss of coverage
☐ Court-ordered coverage
☐ Legal guardianship
☐ Returning from military service

List date of special enrollment event _____/_____/_____ (mm/dd/yyyy)

D. Employee Information

First Name_____ MI_____ Last Name_____ Suffix_____

Date of Birth_____/_____/_____ Gender ☐ Male ☐ Female

Social Security Number[2]

a. ☐ SSN/TIN_____
b. ☐ I do not have a SSN/TIN
c. ☐ I refuse to provide the SSN/TIN

[2]The IRS requires Wellmark to collect SSNs/TINs for federal reporting purposes. Wellmark will follow up with you to collect this information if you do not check/complete a, b, or c. Failure to provide the SSN/TIN information may result in a monetary penalty, per violation, assessed to you by the IRS.

Address Line 1 (Street Address or Apt/Suite#)_____

Address Line 2 (PO Box, Street Address)_____

City_____ State_____ ZIP_____ County_____

Preferred Phone Number (_____)_____ Ext_____ Secondary Phone Number (_____)_____ Ext_____

Email Address_____

Date of Hire_____/_____/_____ Requested Effective Date_____/_____/_____

Employment Status ☐ Active ☐ COBRA ☐ Retired ☐ Seasonal

E. Spouse or Domestic Partner Information

First Name_____ MI_____ Last Name_____ Suffix_____

Date of Birth_____/_____/_____ Gender ☐ Male ☐ Female

☐ Yes ☐ No Is this a domestic partnership?[3]

[3]If yes, please attach a completed Certification of Domestic Partnership (M-4328). For more information, contact your Wellmark representative.

Social Security Number[2]

a. ☐ SSN/TIN_____
b. ☐ I do not have a SSN/TIN
c. ☐ I refuse to provide the SSN/TIN

[2]The IRS requires Wellmark to collect SSNs/TINs for federal reporting purposes. Wellmark will follow up with you to collect this information if you do not check/complete a, b, or c. Failure to provide the SSN/TIN information may result in a monetary penalty, per violation, assessed to you by the IRS.

☐ Yes ☐ No **Is your contact information different than the employee? If yes, complete the following:**

Address (Street Address or Apt/Suite#)_____

City_____ State_____ ZIP_____

County_____ Email Address*_____

*Wellmark may use a member's email addresses to contact members with important information about their Wellmark benefits.

F1. Dependent 1 Information

First Name_____ MI_____ Last Name_____ Suffix_____

Date of Birth____/____/____ Gender ☐ Male ☐ Female

Social Security Number[2]

a. ☐ SSN/TIN_____
b. ☐ I do not have a SSN/TIN
c. ☐ I refuse to provide the SSN/TIN

[2]The IRS requires Wellmark to collect SSNs/TINs for federal reporting purposes. Wellmark will follow up with you to collect this information if you do not check/complete a, b, or c. Failure to provide the SSN/TIN information may result in a monetary penalty, per violation, assessed to you by the IRS.

☐ Yes ☐ No **Is your contact information different than the employee? If yes, complete the following:**

Address (Street Address or Apt/Suite#)_____

City_____ State_____ ZIP_____

County_____ Email Address_____

If your dependent is over the age of 26, the next three questions are required:

☐ Yes ☐ No Are you married? (If yes, this dependent is not eligible for coverage.)
☐ Yes ☐ No Are you a full time student?
If yes, provide the name of the school_____
☐ Yes ☐ No Are you disabled?

F2. Dependent 2 Information

First Name_____ MI_____ Last Name_____ Suffix_____

Date of Birth____/____/____ Gender ☐ Male ☐ Female

Social Security Number[2]

a. ☐ SSN/TIN_____
b. ☐ I do not have a SSN/TIN
c. ☐ I refuse to provide the SSN/TIN

[2]The IRS requires Wellmark to collect SSNs/TINs for federal reporting purposes. Wellmark will follow up with you to collect this information if you do not check/complete a, b, or c. Failure to provide the SSN/TIN information may result in a monetary penalty, per violation, assessed to you by the IRS.

☐ Yes ☐ No **Is your contact information different than the employee? If yes, complete the following:**

Address (Street Address or Apt/Suite#)_____

City_____ State_____ ZIP_____

County_____ Email Address_____

If your dependent is over the age of 26, the next three questions are required:

☐ Yes ☐ No Are you married? (If yes, this dependent is not eligible for coverage.)
☐ Yes ☐ No Are you a full time student?
If yes, provide the name of the school_____
☐ Yes ☐ No Are you disabled?

F3. Dependent 3 Information

First Name_____ MI_____ Last Name_____ Suffix_____

Date of Birth____/____/____ Gender ☐ Male ☐ Female

Social Security Number[2]

a. ☐ SSN/TIN_____
b. ☐ I do not have a SSN/TIN
c. ☐ I refuse to provide the SSN/TIN

[2]The IRS requires Wellmark to collect SSNs/TINs for federal reporting purposes. Wellmark will follow up with you to collect this information if you do not check/complete a, b, or c. Failure to provide the SSN/TIN information may result in a monetary penalty, per violation, assessed to you by the IRS.

F3. Dependent 3 Information, cont'd

☐ Yes ☐ No **Is your contact information different than the employee? If yes, complete the following:**

Address (Street Address or Apt/Suite#)_____

City_____ State_____ ZIP_____

County_____ Email Address_____

If your dependent is over the age of 26, the next three questions are required:

☐ Yes ☐ No Are you married? (If yes, this dependent is not eligible for coverage.)

☐ Yes ☐ No Are you a full time student?

If yes, provide the name of the school_____

☐ Yes ☐ No Are you disabled?

F4. Dependent 4 Information

First Name_____ MI_____ Last Name_____ Suffix_____

Date of Birth_____/_____/_____ Gender ☐ Male ☐ Female

Social Security Number[2]

a. ☐ SSN/TIN_____

b. ☐ I do not have a SSN/TIN

c. ☐ I refuse to provide the SSN/TIN

[2]The IRS requires Wellmark to collect SSNs/TINs for federal reporting purposes. Wellmark will follow up with you to collect this information if you do not check/complete a, b, or c. Failure to provide the SSN/TIN information may result in a monetary penalty, per violation, assessed to you by the IRS.

☐ Yes ☐ No **Is your contact information different than the employee? If yes, complete the following:**

Address (Street Address or Apt/Suite#)_____

City_____ State_____ ZIP_____

County_____ Email Address_____

If your dependent is over the age of 26, the next three questions are required:

☐ Yes ☐ No Are you married? (If yes, this dependent is not eligible for coverage.)

☐ Yes ☐ No Are you a full time student?

If yes, provide the name of the school_____

☐ Yes ☐ No Are you disabled?

G. Other Coverages

Medicare Coverage

Required if Medicare enrolled, absence of a response on questions (1) or (2) will be considered as a response of "No".

1. Are you and/or anyone listed in the Dependent Information sections Social Security disabled? ☐ Yes ☐ No
2. Are you and/or anyone listed in the Dependent Information sections enrolled in Medicare? ☐ Yes ☐ No

If yes, provide Medicare information below for all enrollees with Medicare coverage:

Name as it appears on Medicare card_____ Medicare ID_____

Effective Date (Part A)_____/_____/_____ Effective Date (Part B)_____/_____/_____

Effective Date (Part D)_____/_____/_____

Name as it appears on Medicare card_____ Medicare ID_____

Effective Date (Part A)_____/_____/_____ Effective Date (Part B)_____/_____/_____

Effective Date (Part D)_____/_____/_____

If you need to list more than two dependents, please write all necessary information on a separate sheet of paper and attach to this application.

Other Health Coverage

☐ Yes ☐ No Will you, your spouse or dependent(s) keep other coverage in addition to Wellmark coverage?

If yes, identify those applicants keeping other coverage:

☐ Employee ☐ Spouse ☐ Dependent 1 ☐ Dependent 2 ☐ Dependent 3 ☐ Dependent 4

Other Insurance Carrier Name_____

Address_____

City_____ State_____ ZIP_____

Other Coverage Effective Date_____/_____/_____ Other Coverage End Date_____/_____/_____

Policyholder Name_____ Policy Number_____

Policyholder Date of Birth_____/_____/_____

List name of person that has primary responsibility for the dependents_____

☐ Yes ☐ No Is there a court-ordered document? (If yes, please attach the court order.)

H. Authorization and Certification

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 completing this 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, Avesis Vision & Hearing insurance provided by the vision insurance carrier (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. I further understand that the coverage 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.

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 allowance of benefits to any person thereunder.

I acknowledge I have received or have been advised and understand I will receive from my employer the Summary of Benefits and Coverage (SBC).

The coverage effective date will be assigned according to my employer's eligibility rules and Wellmark guidelines. For special enrollment events, Wellmark must be notified within 60 days of event (or 120 days of returning from military service). The coverage effective dates for special enrollment events will be the 1st of the month following the event. Exceptions are birth, adoption, placement for adoption, legal guardianship, court ordered coverage and foster child placement or otherwise required or permitted under federal or state law. For these events, coverage effective date is the date of the event.

My employer is responsible for compliance with all applicable laws related to employee eligibility waiting periods.

Health Savings Account (HSA)

In the event I have selected a High Deductible Health Plan, I understand that enrolling in such 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.

Providing Social Security Numbers or Tax Identification Numbers

In order for Wellmark to report my coverage status to the federal government, I must provide to Wellmark my Social Security number or tax identification number and the Social Security numbers or tax identification numbers of all members covered under my coverage. The IRS requires that Wellmark report this information using the Social Security number or tax identification number of the plan member and each dependent. If Wellmark does not have Social Security or tax identification numbers, I understand Wellmark will be unable to report and send the information needed to complete federal tax returns. If I have not previously provided Social Security numbers or tax identification numbers to Wellmark for all members covered under my coverage, I will contact Wellmark by calling the Customer Service number on my ID card. If I do not provide the Social Security numbers or tax identification numbers to Wellmark for this purpose, I may be subject to a monetary penalty per violation imposed by the Internal Revenue Service.

H. Authorization and Certification, cont'd

I have read and understand the Authorization and Certification language on this application and acknowledge receipt of a fully completed copy of this application.

Consent to Contact Me Via Residential Telephone, Cellular Phone, Text and Email Messages

☐ By checking this box and entering my signature on this application, I hereby provide my consent to Wellmark to contact me about my Wellmark policy or products and services that may be available to me. Wellmark may provide this information to me using residential telephone, cellular telephone or wireless device, text message or email contact information provided to Wellmark from time to time. If I provide a telephone number for voice calls, I understand that Wellmark may contact me via live or prerecorded calls. I give Wellmark permission to use my personal data (including personally identifiable information) in accordance with Wellmark's privacy policy to determine the types of products and services that may be offered to me. I understand the telephone company or other communications carrier may impose charges for these contacts and that I am not required to give this consent to purchase any goods or services. I understand I may revoke this consent at any time by contacting Wellmark Customer Service.

I authorize the Wellmark agent or agency who is identified with this application or my employer's group application to enter my application information through Wellmark's electronic enrollment process. In the event of any discrepancy between this paper application form and the information entered electronically, the information entered electronically may be considered the source of record, and I may contact Wellmark to make any changes to my enrollment information. Wellmark authorized agents are required to retain this original paper application for 11 years.

Print Name: _____

Your Signature X: _____ **Date Signed:** _____/_____/_____

If applicant is a minor, please sign below. (If legal guardian, please provide proof of guardianship)

Power of Attorney or Legal Guardian Printed Name: _____

Power of Attorney or Legal Guardian Signature X: _____ **Date Signed:** _____/_____/_____