Wellmark Blue Cross and Blue Shield of Iowa is an independent licensee of the Blue Cross and Blue Shield Association.

Application for Employer Group Retiree Health, Dental and Vision Insurance

Mail to: Wellmark Blue Cross and Blue Shield of Iowa
PO Box 9232 - Mail Station 3W294
Des Moines, Iowa 50306-9232
Email: updatesgroupmembership@wellmark.com

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

Complete checked section if you are using this form to:	**A**	**B**	**C**	**D**	**E**	**F**	**H**
Newly enrolling medical program and/or Blue Dental/Silver Vision & Hearing plan(s)	✓	✓	✓	✓	✓		✓
Adding Blue Dental and/or Silver Vision & Hearing plan(s)	✓	✓			✓		✓
Change billing option for current medical program	✓	✓		✓			✓
Change billing option for Blue Dental and/or Silver Vision & Hearing plan(s)	✓	✓			✓		✓
Cancel Blue Dental and/or Silver Vision & Hearing plan(s)	✓	✓				✓	✓
Cancel entire policy	✓	✓				✓	✓

Are you an existing member of this Employer Group Retiree Program? Wellmark ID Number_____

A. Employer Information (Completed by Employer)

Employer Name_____ Effective Date:_____/_____/_____

Employer Group Number_____ Subgroup_____

B. Retiree Information

Name (First, MI, Last)_____

Date of Birth _____/_____/_____ (mm/dd/yyyy) Gender Male ☐ Female ☐

Social Security Number _____ (Social Security Number (SSN) must be provided.)

Physical Address Line 1 (Street Address or Suite#)_____

Physical Address Line 2 (PO Box, Street Address)_____

City_____ State_____ ZIP_____

If mailing address is NOT the same as the physical address listed above, please complete the mailing address information.

Mailing Address Line 1 (Include Street, Bldg Name/No., Apt No.)_____

Mailing Address Line 2 (PO Box, Street Address)_____

City_____ State_____ ZIP_____

Preferred Phone Number (_____) _____

Email Address (optional)_____

C. Medicare Coverage (Required)

Please take out your Medicare ID card and use it to assist you in completing this section of the application.

Fill in the blank spaces so they match your red, white and blue Medicare ID card exactly.

If you have Medicare Part D, what is the effective date?

_____/_____/_____

Name/Nombre: _____

Medicare Number/Número de Medicare:

_____

Entitled to/Con derecho a: Coverage starts/Cobertura empieza

HOSPITAL (Part A) _____/_____/_____

MEDICAL (Part B) _____/_____/_____

D. Choose the program for which you are applying

Check the program for which you are applying: ☐ Program F ☐ High Deductible Program F ☐ Program G ☐ Program N

Choose your method of payment for health program selected

☐ **Yes** ☐ **No** **Will your employer be paying for this program?** (If yes, no other billing information is needed, skip this billing section)

☐ **Yes** ☐ **No** **I will be paying for this program.** (Must complete the following banking information or complete M-5779)

Billing Address (if applicable)

Payer's Name_____

Payer's Mailing Address (Include Street, Bldg. Name/No., Apt No.)_____ PO Box_____

City_____ State_____ ZIP_____

☐ D1. **Direct bill**. On what basis? ☐ Quarterly ☐ Semi-annually ☐ Annually
☐ D2. **Automatic** account withdrawal from applicant's account
☐ D3. **Automatic** account withdrawal from account other than applicant's

If you selected payment method D2. or D3., please complete the following:
On what basis? ☐ Monthly ☐ Quarterly ☐ Semi-annually ☐ Annually
Date of withdrawal: ☐ First of the month ☐ Fifth of the month
From: ☐ Checking ☐ Savings

Complete the following information:

Financial Institution Name_____

Bank Account Name(s) (exactly as it appears on the account)_____

Financial Institution Routing Number (9 digits) _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

Bank Account Number_____

If direct bill is ***not*** selected:
As the bank account holder, I hereby authorize Wellmark to make automatic withdrawals from the account shown above 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.

Authorized Signature of Bank Account Holder (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 next scheduled withdrawal.

E. Choose your optional specialty benefits (You must enroll in health coverage to elect dental and/or vision paln(s)).

1. Select your **Blue Dental℠ plan**. If you do not check a box for a dental plan you will not be enrolled in Blue Dental coverage. **You must reside in Iowa to enroll in a dental plan.**

   a. Select one Blue Dental℠ plan
   ☐ Blue Dental℠ 75
   ☐ Blue Dental℠ 100
   ☐ I do not want dental coverage (existing Blue Dental coverage will be canceled)

   To determine full or partial waiting periods for dental coverage please complete b.

   b. Have you had other dental coverage, without a lapse of more than 63 days, prior to the effective date of this application?
   ☐ Yes ☐ No

   If yes[1]:
   Insurance Company Name_____ Policy ID_____

   START_____/_____/_____ END_____/_____/_____

   [1]If yes is marked and you do not complete the rest of this section, the full dental waiting period will be applied.

   If you have other dental coverage currently in force, and you intend to replace that coverage with a Blue Dental plan, please read the "Notice to Applicant Regarding Replacement of Accident and Sickness Insurance" in section H.

E. Choose your optional benefits, cont'd

2. Select your **Avesis Silver Vision & Hearing**[2] plan. If you do not check a box for a vision plan you will not be enrolled in Silver Vision & Hearing coverage. **You must reside in Iowa or South Dakota to enroll in a vision plan.**

Select one Avesis Silver Vision & Hearing plan

☐ Silver Vision & Hearing 100
☐ Silver Vision & Hearing 130
☐ I do not want Silver Vision & Hearing (existing Silver Vision & Hearing will be canceled)

[2]Silver Vision & Hearing plans are administered by Avesis, an independent vision insurance company that does not provide Wellmark Blue Cross and Blue Shield products and services. Avesis Silver Vision & Hearing plans are underwritten by Fidelity Security Life Insurance Company®, Kansas City, Missouri. Silver Vision & Hearing plans include hearing discount savings plans provided by Amplifon. Amplifon is an independent company that does not provide Wellmark Blue Cross and Blue Shield products or services.

Choose your method of payment for optional benefits selected (required)

Billing Address (if applicable)

Payer's Name_____

Payer's Mailing Address (Include Street, Bldg. Name/No., Apt No.)_____ PO Box_____

City_____ State_____ ZIP_____

☐ E3. **Direct bill**. On what basis? ☐ Quarterly ☐ Semi-annually ☐ Annually
☐ E4. **Automatic** account withdrawal from applicant's account
☐ E5. **Automatic** account withdrawal from account other than applicant's

If you selected payment method E4. or E5., please complete the following:
On what basis? ☐ Monthly ☐ Quarterly ☐ Semi-annually ☐ Annually
Date of withdrawal: ☐ First of the month ☐ Fifth of the month
From: ☐ Checking ☐ Savings

Complete the following information:

Financial Institution Name_____

Bank Account Name(s) (exactly as it appears on the account)_____

Financial Institution Routing Number (9 digits) _ _ _ _ _ _ _ _ _

Bank Account Number_____

If direct bill is ***not*** selected:
As the bank account holder, I hereby authorize Wellmark to make automatic withdrawals from the account shown above 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.

The member will be responsible for any fee assessed by their bank for stop-payment orders that the member makes as well as the $25 fee assessed by Wellmark for a returned (not honored) payment and an additional $25 reinstatement fee if the policy terminates.

Authorized Signature of Bank Account Holder (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 next scheduled withdrawal.

F. Termination (If you terminate your health benefit, it will terminate all benefits)

☐ Terminate Blue Dental
☐ Terminate Silver Vision & Hearing
☐ Terminate my entire policy

Date: _____/_____/_____ (Earliest termination date will be the end the month in which the form is received)

G. Statements

1. You do not need more than one Medicare supplement policy or other policy providing coverage supplemental to Medicare.
2. If you purchase this policy (certificate), 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 policy supplemental to Medicare.
4. Counseling services may be available in your state to provide advice concerning your purchase of a policy supplemental to Medicare 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).

H. Application Agreement and Certification

My signature verifies that, to the best of my knowledge and belief, I have completed this application accurately 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 assigns an effective date of coverage.

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.

Notice to Applicant Regarding Replacement of Accident and Sickness Insurance

If you currently have existing limited scope dental, hearing, or vision insurance, and you intend to lapse or otherwise terminate that existing coverage, and replace it with Blue Dental and/or Avesis Vision coverage in this application, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy.

1. Health conditions you may presently have, may not be fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been paid under your current policy.
2. You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.
3. If after due consideration you still wish to terminate our present policy and replace it with a new coverage, be certain to read this application and truthfully and completely answer all questions on the application. Failure to include all material and accurate information, including medical information, may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in forced. After the application has been completed and before you sign it, reread it carefully to be certain all information has been properly recorded.

Dental Waiting Periods

In the event I am adding dental coverage, I certify that I have been informed that waiting periods apply. I understand this dental coverage waiting period may be waived or reduced if I have qualifying existing coverage or qualifying previous coverage.

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 service. I understand I may revoke this consent at any time by contacting Wellmark Customer Service.

Applicant Signature_____ Date_____/_____/_____

OR

Power of Attorney (POA) or Legal Guardian (if applicable):

NOTE: If POA or legal guardian, include a copy of the general POA granting such authority. Do not include a copy of the medical or durable POA.

POA or Legal Guardian Name (please print)_____

POA or Legal Guardian Signature X_____ Date _____/_____/_____

Wellmark Language Assistance

Discrimination is against the law

Wellmark Blue Cross and Blue Shield complies with applicable state and federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex, sexual orientation, or gender identity.

Wellmark provides:

- Free aids and services to people with disabilities so they may communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

You have the right to get this information and help in your language for free.
If you need these services, call 800-524-9242.

ATENCIÓN: Si habla español, los servicios de asistencia de idiomas se encuentran disponibles gratuitamente para usted. Comuníquese al 800-524-9242 o al (TTY: 888-781-4262).

注意： 如果您说普通话， 我们可免费为您提供语言协助服务。 请拨打 800-524-9242 或 （听障专线： 888-781-4262）。

CHÚ Ý: Nếu quý vị nói tiếng Việt, các dịch vụ hỗ trợ ngôn ngữ miễn phí có sẵn cho quý vị. Xin hãy liên hệ 800-524-9242 hoặc (TTY: 888-781-4262).

NAPOMENA: Ako govorite hrvatski, dostupna Vam je besplatna podrška na Vašem jeziku. Kontaktirajte 800-524-9242 ili (tekstualni telefon za osobe oštećena sluha: 888-781-4262).

ACHTUNG: Wenn Sie deutsch sprechen, stehen Ihnen kostenlose sprachliche Assistenzdienste zur Verfügung. Rufnummer: 800-524-9242 oder (TTY: 888-781-4262).

تنبيه: إذا كنت تتحدث اللغة العربية, فإننا نوفر لك خدمات المساعدة اللغوية، المجانية. اتصل بالرقم 800-524-9242 أو (خدمة الهاتف النصي: 888-781-4262).

ສ່ວນຄວນເອົາໃຈໃສ່, ພາສາລາວ ຖ້າທ່ານເວົ້າ: ພວກເຮົາມີບໍລິການຄວາມຊ່ວຍເຫຼືອດ້ານພາສາໃຫ້ທ່ານໂດຍ ບໍ່ເສຍຄ່າ ຫຼື 800-524-9242 ຕິດຕໍ່ຫາ. (TTY: 888-781-4262.)

주의: 한국어 를 사용하시는 경우, 무료 언어 지원 서비스를 이용하실 수 있습니다. 800-524-9242번 또는 (TTY: 888-781-4262)번으로 연락해 주십시오.

ध्यान रखें : अगर आपकी भाषा हिन्दी है, तो आपके लिए भाषा सहायता सेवाएँ, नि:शुल्क उपलब्ध हैं। 800-524-9242 पर संपर्क करें या (TTY: 888-781-4262)।

ATTENTION : si vous parlez français, des services d'assistance dans votre langue sont à votre disposition gratuitement. Appelez le 800 524 9242 (ou la ligne ATS au 888 781 4262).

Geb Acht: Wann du Deitsch schwetze duscht, kannscht du Hilf in dei eegni Schprooch koschdefrei griege. Ruf 800-524-9242 odder (TTY: 888-781-4262) uff.

โปรดทราบ: หากคุณพูด ไทย เรามีบริการช่วยเหลือด้านภาษาสำหรับคุณโดยไม่คิดค่าใช้จ่าย ติดต่อ 800-524-9242 หรือ (TTY: 888-781-4262)

PAG-UKULAN NG PANSIN: Kung Tagalog ang wikang ginagamit mo, may makukuha kang mga serbisyong tulong sa wika na walang bayad. Makipag-ugnayan sa 800-524-9242 o (TTY: 888-781-4262).

တtill်းသင့်ည၊–နမ့်ကတိၤကညီကျိာ်,ကျိာ်တါမၤစၢၤတါဖံးတါမၤတဖဉ်,လၢတဘဉ်လၢာ်ဘူးလဲ,ဆိဉ်လၢနဂီၤလီၤ.ဆဲးကျိုးဆူ ၈၀၀–၅၂၄–၉၂၄၃မ့တမ့်(TTY:၈၈၈–၇၈၁–၄၂၆၂)တကွ်.

ВНИМАНИЕ! Если ваш родной язык русский, вам могут быть предоставлены бесплатные переводческие услуги. Обращайтесь 800-524-9242 (телетайп: 888-781-4262).

सावधान: यदि तपाईं नेपाली बोल्नुहुन्छ भने, तपाईंका लागि नि:शुल्क रूपमा भाषा सहायता सेवाहरू उपलब्ध गराइन्छ । 800-524-9242 वा (TTY: 888-781-4262) मा सम्पर्क गर्नुहोस् ।

ማሳሰቢያ: አማርኛ የሚናገሩ ከሆነ፣ የቋንቋ እገዛ አገልግሎቶች፣ ከክፍያ ነፃ፣ ያገኛሉ። በ 800-524-9242 መደም (በTTY: 888-781-4262) ይውለው ያነጋግሩን።

HEETINA To a wolwa Fulfulde laabi walliinde dow wolde, naa e njobdi, ene ngoodi ngam maaɗa. Heƃir 800-524-9242 malla (TTY: 888-781-4262).

FUULEFFANNAA: Yo isin Oromiffaa, kan dubbattan taatan, tajaajiloonni gargaarsa afaanii, kaffaltii malee, isiniif ni jiru. 800-524-9242 yookin (TTY: 888-781-4262) quunnamaa.

УВАГА! Якщо ви розмовляєте українською мовою, для вас доступні безкоштовні послуги мовної підтримки. Зателефонуйте за номером 800-524-9242 або (телетайп: 888-781-4262).

Ge': Diné k'ehjí yáníłti'go níká bizaad bee áká' adoowoł, t'áá jiik'é, náhóló. Kojį' hólne' 800-524-9242 doodaii' (TTY: 888-781-4262)

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