Wellmark BlueCross BlueShield 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 Insurance

☐ New Hire ☐ Late Enrollee ☐ Special Enrollee ☐ Change

This area completed by Employer: Group/Billing Unit No. 72521-000 Department No. _____ Effective Date _____

Employer Name: City of Iowa City Employer Address: 410 E. Washington St., Iowa City, IA 52240

### A. Employee Information

Name (First, Last): _____ Hire Date: ____/____/____

Address: _____ ☐ Male ☐ Female Birthdate: ____/____/____

City: _____ State: _____ Zip: _____ Marital Status: ☐ Single ☐ Married

Telephone: (____) _____ E-mail Address (optional) _____ Social Security Number (required): _____

Employment Status: ☐ Full-Time ☐ Part-Time ☐ Retiree ☐ COBRA ☐ Yes ☐ No Soc. Sec. Disabled? ☐ Yes ☐ No Medicare Enrolled?

**Health:** ☐ Employee ☐ Employee/Spouse ☐ Employee/Child(ren) ☐ Employee/Spouse/Child(ren) **Health Plan Code:** ☐ 22S ☐ 6VZ ☐ 6VY **Deductible Amount:** _____

### 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/Enrollees 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 PREFERRED FOR DEPENDENTS | Gender | Full-Time Student? | Soc. Sec. Disabled? | Medicare Enrolled? |
|---|---|---|---|---|---|---|
| Spouse | / / | | ☐ M ☐ F | | ☐ Yes ☐ No | ☐ Yes ☐ No |
| Dependent | / / | | ☐ M ☐ F | ☐ Yes | ☐ Yes ☐ No | ☐ Yes ☐ No |
| Dependent | / / | | ☐ M ☐ F | ☐ Yes | ☐ Yes ☐ No | ☐ Yes ☐ No |
| Dependent | / / | | ☐ M ☐ F | ☐ Yes | ☐ Yes ☐ No | ☐ Yes ☐ No |
| Dependent | / / | | ☐ M ☐ F | ☐ Yes | ☐ Yes ☐ No | ☐ Yes ☐ No |

### D. Medicare Coverage

Name of person covered by Medicare: _____ Effective Date (Part A): _____/_____/_____

Medicare ID (HIC) No.: _____ 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:

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

Policyholder Name (First, Last): _____ Date of Birth: ___/___/___ Policy No.: _____

Employer Name (if coverage is through employer group): _____ Effective Date: ____/____/____

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

Is there a divorce decree/court order that requires one parent to provide health insurance coverage for any dependent? ☐ Yes ☐ No 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 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 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: ____/____/____

### G. Waiver of Enrollment (Please complete if you are waiving health 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.

Please see the Important Information Regarding Waiver of Enrollment section on the back of this application.

### H. Authorization and Certification

I have read and understand the Important Information Regarding Waiver of Enrollment and Authorization and Certification language on the back of this application and acknowledge receipt of a fully completed copy of this application.

Employee Signature _____ Date ____/____/____

N-5408 4/09

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## Important Information Regarding Waiver of Enrollment

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 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 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., P.O. Box 9232, Station 9, Des Moines, IA 50306-9232, or call 800-524-9242.

## 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 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"). 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 Wellmark on my behalf. This authorization is to remain in effect until Wellmark is 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 coverages applied for will not start until after this application and the appropriate coverage rates are received and accepted by Wellmark and an effective date of coverage is established by Wellmark.

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 Wellmark 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, Wellmark will be entitled to declare the contracts applied for void and to refuse 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.

I authorize any health care provider, including but not limited to; surgeon, physician, psychologist, nurse, social worker, or health care facility to release to Wellmark 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 Wellmark or the 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.

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