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.______ Department No.______ Effective Date______

Employer Name: ______ Employer Address: ______

A. Employee Information

Name (First, Last):______ Soc. Sec. Disabled? ☐ Yes ☐ No Medicare Enrolled? ☐ Yes ☐ No

Address:______ ☐ Male ☐ Female Birthdate: ___/___/___

City, State, Zip:______ Marital Status: ☐ Single ☐ Married ☐ Common Law

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

Employment Status: ☐ Full-Time ☐ Part-Time ☐ Retiree ☐ COBRA Hire Date: ___/___/___

B Members/Enrollees Covered (Please indicate who you are choosing to cover.)

Health: ☐ Self ☐ Spouse ☐ Child(ren) **Health Coverage Selected:** ______ **HSA:** ☐ Yes ☐ No

List Name (First, Last) of all others to be covered	Birthdate	Social Security Number	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

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

☐ Marriage ☐ Death ☐ Divorce ☐ Birth/Adoption ☐ Change of Spouse's Employment ☐ Other, Specify: ______ Date of Event: ___/___/___

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

☐ Yes ☐ No Will you, your spouse or your dependents keep other health coverage in addition to this Wellmark, Inc. coverage? Please list those covered by other health plan(s):______

If yes, please complete the following:

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, please complete the following:

Name 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.

Note: 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 after the marriage, birth, adoption or placement for adoption. 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.

H. Authorization and Certification

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

EmployeeSignature______ Date______

White – Wellmark, Inc. Yellow – Employer Pink – Member/Enrollee