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

Application for MedicareBlue Supplement℠

Requested Effective Date
_____/_____/_____

A. Tell us about yourself.

Applicant Name *(First, Middle, Last)*		
Date of Birth *(mm/dd/yyyy)* _____/_____/_____	Gender ☐ Male ☐ Female	Social Security Number
Daytime Phone ( )	Email Address *(optional)*	

Address Information:

Physical Address *(Include Street, Bldg Name/No., Apt. No.)*	County Name	
City	State	ZIP

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

Mailing Address *(Include Street, Bldg Name/No., Apt. No.)*	PO Box	
City	State	ZIP

B. Tell us about your tobacco usage.

Note: You are required to answer this question. However, if you are applying during a guaranteed issue rights period or during your six-month Medicare Supplement Open Enrollment Period only the non-tobacco user premium will apply.

☐ Yes ☐ No **B1.** Have you used tobacco during the 12 months immediately preceding the effective date of this application?

C. Provide us with your Medicare information.

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.

MEDICARE HEALTH INSURANCE

Name: _____

Medicare Number: Sex (M/F): _____

_____- ____- _____

Is Entitled to: Effective Date *(mm/dd/yyyy)*:

HOSPITAL (Part A) _____/_____/_____

MEDICAL (Part B) _____/_____/_____

Applicant Name (First, Middle, Last)	Social Security Number

C. Provide us with your Medicare information, cont'd.

☐ Yes ☐ No **C1.** Did you turn age 65 in the last six months?

☐ Yes ☐ No **C2.** Did you enroll in Medicare Part B in the last six months?

If yes, what is your Part B effective date (*mm/dd/yyyy*)? _____/_____/_____

☐ Yes ☐ No **C3.** Are you applying for a plan effective date within six months after:

- your Medicare Part B effective date and turning 65 (or older)?

OR

- the first day of the month in which you turn age 65 (or the first day of the month prior to the month in which you turn 65 if your birth date is the first day of the month) **and** are currently enrolled in Medicare Part B?

STOP

If you answered **YES** to question C3 above, you are within your Medicare Supplement Open Enrollment Period and your acceptance is guaranteed. You do **not** have to answer health questions and can proceed to Section G of the application to select your plan. You are eligible for Plans A, D, F, High Deductible F, G, and N. To determine your monthly premium amount, refer to the MedicareBlue Supplement - Preferred Non-Tobacco premium table in the Outline of Coverage for Plans D, F, High Deductible F, G, and N, and to the MedicareBlue Supplement - Standard Non-Tobacco premium table in the Outline of Coverage for Plan A.

If you answered **NO** to question C3 above, please continue to Section D to determine if your acceptance is guaranteed.

D. Review the following loss of coverage situations to determine if your acceptance is guaranteed.

If your previous coverage terminated or ceased to provide some benefits more than 63 days prior to the date of this application, you are outside of your guaranteed issue rights period. You must complete the entire application including answering the health questions. Please go to Section E to determine the plan(s) for which you are eligible.

If you lost or are losing other health insurance coverage and received a notice from your previous insurer and/or employer saying that you are eligible for guaranteed issue of Medicare supplement insurance policy, or that you have certain rights to buy such a policy, you may be a guaranteed acceptance in one or more of our Medicare supplement plans.

If one of these situations applies to you, check the appropriate box at the left and then provide the date your coverage was effective and/or the date your coverage will end *(mm/dd/yyyy)*. **Check one only.**

☐ Applies to me **D1.** I am enrolled in a Medicare Advantage plan, and my plan is leaving Medicare or will no longer be providing coverage in my area, or I have moved out of my plan's service area.

If applicable, please provide the date coverage will end _____/_____/_____

Applicant Name (First, Middle, Last)	Social Security Number

D. Review the following loss of coverage situations to determine if your acceptance is guaranteed, cont'd.

☐ Applies to me **D2.** I have Original Medicare and an employer group health plan that pays after Medicare pays and that plan has stopped providing some or all health benefits (only applies to involuntary loss of coverage.)

If this applies to you, check the option that describes your situation below:
- ☐ a. Retiree coverage is being terminated by the employer
- ☐ b. COBRA eligibility has expired
- ☐ c. Group coverage with under 20 employees is ending
- ☐ d. After 30 months of coverage for end stage renal disease

If applicable, please provide the date coverage will end _____/_____/_____

☐ Applies to me **D3.** I have Original Medicare and a Medicare Select policy, and I am moving out of the Medicare Select policy's service area.

If applicable, please provide the date coverage will end _____/_____/_____

☐ Applies to me **D4.** I joined a Medicare Advantage plan or Programs for All-Inclusive Care for the Elderly (PACE) when I was first eligible for Medicare Part A or B at age 65, and within the first year of joining, I want to disenroll (Trial Right).

If applicable, please provide the date coverage was effective _____/_____/_____; and the date coverage will end _____/_____/_____

☐ Applies to me **D5.** I canceled my Medicare supplement policy to join a Medicare Advantage plan (or to switch to a Medicare Select policy) for the first time, have been in the plan less than one year, and want to re-enroll in my original Medicare supplement policy or my original Medicare supplement policy is no longer available (Trial Right).

If applicable, please provide the date coverage was effective _____/_____/_____; and the date coverage will end _____/_____/_____

☐ Applies to me **D6.** I have Medicare supplement insurance, and I am losing my coverage because the insurance company went bankrupt, or my coverage is ending through no fault of my own.

If applicable, please provide the date coverage will end _____/_____/_____

☐ Applies to me **D7.** I am leaving a Medicare Advantage plan or a Medicare supplement policy because I have been notified the insurance company has violated a provision of its contract with me or it misled me.

If applicable, please provide the date coverage will end _____/_____/_____

STOP

If you checked any of the situations above **and** your coverage did not end (or cease to provide some benefits) more than 63 days before the date of this application, your acceptance may be guaranteed. You do **not** have to answer health questions and can proceed to Section G of the application to select your plan. You are eligible for Plans A, D, F, High Deductible F, G, and N. To determine your monthly premium amount, refer to the MedicareBlue Supplement - Preferred Non-Tobacco premium table in the Outline of Coverage for Plans D, F, High Deductible F, G, and N, and to the MedicareBlue Supplement - Standard Non-Tobacco premium table in the Outline of Coverage for Plan A.

If none of the situations above apply to you, you must complete the entire application including answering the health questions. Please continue to Section E to determine the plan(s) for which you are eligible.

Applicant Name (First, Middle, Last)	Social Security Number

E. Answer the following health questions to determine the plan(s) for which you are eligible.

☐ Yes ☐ No **E1.** Do any of the following situations apply to you?
- Currently in the hospital or have been an inpatient within the last 90 days (excluding outpatient or overnight/observation beds)
- Receive or require dialysis
- Require bottled oxygen or an oxygen concentrator to help you breathe (this does not include the use of a CPAP machine for sleep apnea)

☐ Yes ☐ No **E2.** In the last two years, have you received medical advice, or testing **in preparation for** any of the following surgical procedures? (If the actual surgical procedure has already been completed, you may respond 'no' to this question.)
- Heart or bypass surgery (this includes having a pacemaker or defibrillator implanted, but not updates to an existing pacemaker such as replacement of the battery)
- Angioplasty or vascular surgery
- Back or spine surgery
- Joint replacement
- Surgery for any form of cancer
- Surgery to remove any type of tumor
- Amputation due to disease
- Organ transplant

☐ Yes ☐ No **E3.** In the last two years, have you received medical advice, treatment, or prescription medications from a health care professional for any of the following conditions?
- Liver problems related to cirrhosis, or hepatitis B or C
- Any form of cancer including leukemia, lymphoma, or melanoma (except basal cell and squamous cell skin cancer)
- Stroke or transient ischemic attack (TIA)
- Amyotrophic lateral sclerosis (ALS)
- Multiple sclerosis (MS)
- Acquired immune deficiency syndrome (AIDS) or tested positive for HIV
- Kidney or renal disease related to chronic renal failure
- Paraplegia or quadriplegia

STOP

If you answered **YES** to **any** of the questions in Section E above, you are only eligible for Plan A at the **standard** premium. To determine your monthly premium amount, refer to the MedicareBlue Supplement standard premium tables in the Outline of Coverage. Please go to Section G and select Plan A.

If you answered **NO** to **all** of the questions in Section E above, you are eligible for Plan A, D, F, High Deductible F, G, and N at the **standard** premium. Please proceed to Section F to determine if you qualify for preferred premiums.

Applicant Name (First, Middle, Last)	Social Security Number

F. Review the list of health conditions and answer the following health questions to determine if you qualify for preferred premiums.

Circulatory conditions
- Aneurysm
- Artery blockage
- Atrial fibrillation or flutter
- Cardiomyopathy
- Carotid artery disease
- Congestive heart failure
- Coronary artery disease
- Heart attack
- Peripheral artery disease
- Ventricular tachycardia
- Deep vein thrombosis or blood clot(s) in vein
- Hemophilia

Metabolic conditions
- Diabetes with one or more complications (such as: neuropathy/ nerve damage, kidney disease, or retinopathy)
- Diabetes requiring an insulin pump

Substance abuse
- Alcohol abuse or alcoholism
- Drug abuse or use of illegal drugs

Respitory conditions
- Chronic obstructive pulmonary disease (COPD)
- Emphysema
- Chronic bronchitis
- Chronic asthma
- Chronic interstitial lung disease
- Chronic pulmonary fibrosis
- Cystic fibrosis
- Sarcoidosis
- Bronchiectasis

Kidney conditions
- Polycystic kidney disease
- Renal artery stenosis
- Chronic renal insufficiency

Gastrointestinal conditions
- Chronic pancreatitis
- Esophageal varices

Musculoskeletal conditions
- Amputation due to disease
- Rheumatoid arthritis (RA)
- Spinal stenosis
- Osteoporosis with fracture

Organ transplant
- Organ transplant
- Bone marrow transplant

Auto-immune disorders or connective tissue disorders
- Scleroderma
- Systemic lupus erythematosus (SLE)

Psychological or mental disorders
- Bipolar or manic depressive
- Major depressive disorder
- Schizophrenia
- Anorexia nervosa

Eye condition
- Retinopathy

Neurological or nervous system conditions
- Hemiplegia (paralyzed on one side)
- Alzheimer's disease, dementia or cognitive disorders
- Parkinson's disease
- Myasthenia gravis
- Seizure disorders

☐ Yes ☐ No **F1.** In the last two years, have you been diagnosed, treated, or been prescribed medication by a health care professional for any of the conditions listed above? You must also respond 'yes' to this question if you are currently receiving treatment and/or taking a medication to treat any of the conditions listed. (If you are uncertain as to whether a listed condition applies to you, please consult with your physician as to your specific diagnosis.)

STOP

If you answered **YES** to question F1 above, you qualify for Plans A, D, F, High Deductible F, G, and N at the **standard** premium. To determine your monthly premium amount, refer to the MedicareBlue Supplement standard premium tables in the Outline of Coverage. Please proceed to Section G and select your plan.

If you answered **NO** to question F1 above, you qualify for Plans D, F, High Deductible F, G, and N at the **preferred** premium. To determine your monthly premium amount, refer to the MedicareBlue Supplement preferred premium tables in the Outline of Coverage. You are also eligible for Plan A at **standard** premium. Please proceed to Section G and select your plan.

Applicant Name (First, Middle, Last)	Social Security Number

G. Choose the plan for which you are applying.

1. Check the MedicareBlue Supplement plan for which you are applying:
   ☐ Plan A ☐ Plan D ☐ Plan F ☐ High Deductible Plan F ☐ Plan G ☐ Plan N
2. Select your Blue Dental℠ and/or Silver Vision & Hearing* plan(s). If you do not check a box for plan(s) you will not be enrolled in optional coverage. For current MedicareBlue Supplement members, if you do not complete this section of the application, you will remain enrolled on your existing Blue Dental and/or Silver Vision & Hearing plan(s).

   Select one Blue Dental℠ and/or one Silver Vision & Hearing plan

   ☐ Blue Dental℠ 100
   ☐ Blue Dental℠ 75
   ☐ Not electing Blue Dental at this time
   ☐ Silver Vision & Hearing 130
   ☐ Silver Vision & Hearing 100
   ☐ Not electing Silver Vision & Hearing at this time

*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.

H. Answer the following questions about your past and current coverage.

Please answer all questions.

(Answer questions below by marking YES or NO with an "X".) To the best of your knowledge:

☐ Yes ☐ No **H1.** Are you covered for medical assistance through the state Medicaid program?
(NOTE TO APPLICANT: If you are participating in a "spend-down program" and have not met your "share of cost," please answer NO to this question.)
If yes,

☐ Yes ☐ No (a) Will Medicaid pay your premiums for this Medicare supplement policy?

☐ Yes ☐ No (b) Do you receive any benefits from Medicaid OTHER THAN payments toward your Medicare Part B premium?

☐ Yes ☐ No **H2.** Have you had coverage from any Medicare plan other than Original Medicare within the past 63 days (this includes a Medicare Advantage plan, or a Medicare HMO or PPO)?
If yes,
(a) Fill in your start and end dates below. If you are still covered under this plan, leave "END" blank.
START _____/_____/_____ END _____/_____/_____
(b) With what insurance company, and what kind of policy?

_____

_____

☐ Yes ☐ No (c) If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare supplement policy? **If yes, you must complete "Notice to Applicant Regarding Replacement of Medicare Supplement Insurance or Medicare Advantage" on the last page of this application.**

☐ Yes ☐ No (d) Was this your first time in this type of Medicare plan?

☐ Yes ☐ No (e) Did you drop a Medicare supplement policy to enroll in the Medicare plan?

☐ Yes ☐ No (f) If yes, with what insurance company was your Medicare supplement policy?

_____

Applicant Name (First, Middle, Last)	Social Security Number

H. Answer the following questions about your past and current coverage, cont'd

☐ Yes ☐ No **H3.** Do you have another Medicare supplement policy in force with any carrier including Wellmark?
If yes,
(a) With what insurance company, and what plan do you have?

_____

☐ Yes ☐ No (b) Do you intend to replace your current Medicare supplement policy with this policy?
If yes, you must complete "Notice to Applicant Regarding Replacement of Medicare Supplement Insurance or Medicare Advantage" on the last page of this application.

(c) If yes, What is the paid-to or expiration date of your policy? _____/_____/_____

☐ Yes ☐ No **H4.** Have you had coverage under any other health, vision, hearing, or dental insurance within the past 63 days?
(This includes, an employer, union, or individual plan.)
If yes,
(a) With what insurance company, what kind of policy, and employer name (if applicable)?

_____

_____

(b) What are your dates of coverage under the other policy? If you are still covered under the other policy, leave "END" blank.

START _____/_____/_____ END _____/_____/_____

If you have other health, vision, hearing, or dental coverage currently in force, and you intend to replace that coverage with a Silver Vision & Hearing plan, or a Blue Dental plan, please read the "Notice to Applicant Regarding Replacement of Accident and Sickness Insurance" on page 9.

I. Choose your method of payment.

Select how you would like to pay for your MedicareBlue Supplement premiums from one of the options below. Billing periods are based on a calendar year. Please do not send payment with this application. If the bank account holder is not present to sign the application, you will need to complete and submit an Automatic Payment Authorization Form (M-5779).

Payer's Billing Information (if different from applicant's mailing address):

Payer's Name:		
Payer's Mailing Address *(Include Street, Bldg Name/No., Apt. No.)*	PO Box	
City	State	ZIP

Applicant Name (First, Middle, Last)	Social Security Number

I. Choose your method of payment, cont'd.

☐ I1. **Direct bill.** On what basis? ☐ Quarterly ☐ Semi-annually ☐ Annually

☐ I2. **Automatic account withdrawal from applicant's account**

☐ I3. **Automatic account withdrawal from account other than applicant's**

If you selected payment method I2 or I3, 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

Attach a voided check in the space designated below <u>OR</u> complete the following information:

Financial Institution Name: _____

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

Financial Institution Routing Number (9 digits): _____

Account Number: _____

State Code (found on your check on the top right corner above the date -- e.g., 78): _____

If direct bill is ***not*** selected:
As the bank account holder, I hereby authorize Wellmark to make automatic withdrawals from the account shown above (or on the attached voided check below) 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.

Bank Account Holder's Signature (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.

TAPE VOIDED CHECK HERE

<u>OR</u>

PROVIDE FINANCIAL INFORMATION IN THE SPACES PROVIDED ABOVE

(DO NOT STAPLE OR COVER LANGUAGE ABOVE OR BELOW THIS SPACE)

Applicant Name (First, Middle, Last)	Social Security Number

Statements

1. You do not need more than one Medicare supplement policy.
2. If you purchase this policy, 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 Medicare supplement policy.
4. If, after purchasing this policy, you become eligible for Medicaid, the benefits and premiums under your Medicare supplement policy can be suspended, if requested, during your entitlement to benefits under Medicaid for 24 months. You must request this suspension within 90 days of being notified of Medicaid eligibility. If you are no longer entitled to Medicaid, your suspended Medicare supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstated if requested within 90 days of losing your Medicaid eligibility. If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstated policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.
5. If you are eligible for, and have enrolled in a Medicare supplement policy by reason of disability and you later become covered by an employer or union-based group health plan, the benefits and premiums under your Medicare supplement policy can be suspended, if requested, while you are covered under the employer or union-based group health plan. If you suspend your Medicare supplement policy under these circumstances, and later lose your employer or union-based group health plan, your suspended Medicare supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstated if requested within 90 days of losing your employer or union-based group health plan. If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstated policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.
6. Counseling services may be available in your state to provide advice concerning your purchase of Medicare supplement insurance 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).

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 the coverage identified 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 beneftis 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 your present policy and replace it with 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 force. After the application has been completed and before you sign it, reread it carefully to be certain all information has been properly recorded.

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Application Agreement and Certification

My signature on this application verifies that I have received the "MedicareBlue Supplement Outline of Coverage," the "Guide to Health Insurance for People with Medicare," and a completed copy of this application. My signature also verifies that I have read and understand the "Statements" section that appears above.

My signature verifies that, to the best of my knowledge and belief, I have answered the questions on this application truthfully 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 applicable payment and assigns an effective date of coverage. If I answered "No" to the tobacco question on this application, I am eligible for a special tobacco non-user premium. If this status changes, I must notify Wellmark immediately. Wellmark may require me to recertify this status in the future.

My signature further verifies that I understand Iowa law prohibits knowingly selling more than one Medicare supplement policy to an individual. I certify that if I currently have a Medicare supplement policy in force, I will cancel my current Medicare supplement policy upon notification of acceptance for coverage by Wellmark Blue Cross and Blue Shield of Iowa. I can request that a Wellmark Blue Cross and Blue Shield of Iowa representative review my existing policies and advise whether this MedicareBlue Supplement policy will duplicate the benefits of my existing health insurance policies by calling (800) 336-0505.

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.

My signature on this application verifies that I have received the "MedicareBlue Supplement Outline of Coverage," the "Guide to Health Insurance for People with Medicare," and a completed copy of this application. My signature also verifies that I have read and understand the "Statements" section that appears above.

My signature verifies that, to the best of my knowledge and belief, I have answered the questions on this application truthfully 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 applicable payment and assigns an effective date of coverage. If I answered "No" to the tobacco question on this application, I am eligible for a special tobacco non-user premium. If this status changes, I must notify Wellmark immediately. Wellmark may require me to recertify this status in the future.

My signature further verifies that I understand Iowa law prohibits knowingly selling more than one Medicare supplement policy to an individual. I certify that if I currently have a Medicare supplement policy in force, I will cancel my current Medicare supplement policy upon notification of acceptance for coverage by Wellmark Blue Cross and Blue Shield of Iowa. I can request that a Wellmark Blue Cross and Blue Shield of Iowa representative review my existing policies and advise whether this MedicareBlue Supplement policy will duplicate the benefits of my existing health insurance policies by calling (800) 336-0505.

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.

If a condition arises that would have caused an ordinary prudent person to seek medical advice, diagnosis, care or treatment or a condition arose for which medical advice, diagnosis, care or treatment was received or recommended, regardless of the date I signed the application or the date the application was acted upon by Wellmark, I will so inform Wellmark by sending this information in writing to:

Wellmark Blue Cross and Blue Shield of Iowa
PO Box 14527, Mail Station 3W190
Des Moines, IA 50306-3527

I understand that premium payments may be made on a calendar month, calendar quarter, semi-annual calendar year or calendar year basis. For example, a monthly premium payment would be for the first day of a month through the last day of such month. A quarterly premium payment would be for any calendar quarterly period, such as January 1 through March 31. A semi-annual premium would be for the period of either January 1 through June 30 or July 1 through December 31. An annual premium payment would be from January 1 through December 31 of the applicable year.

In the event I choose to pay my premium on a quarterly, semi-annual, or annual basis and there is a mid-year increase in the amount of premium(s), I will have the

Applicant Name (First, Middle, Last)	Social Security Number

Application Agreement and Certification, cont'd

following responsibility with regard to an increase in premium(s).

- Quarterly payments: For quarterly premium payments, I must pay the remaining quarterly premium payments that include the premium increase.
- Semi-annual payments: For semi-annual premium payments, I must pay a bill for a premium payment that equals the difference between the new semi-annual premium amount and the previously paid first semi-annual premium amount. I also will be required to pay a second semi-annual premium amount that includes the premium increase.
- Annual payment: For annual premium payments, I must pay a bill for a premium payment that equals the difference between the new annual premium amount and the previously paid annual premium amount.

My signature additionally verifies that I understand and agree that the amount of my periodic premium payment will change as provided in the policy being applied for and from time to time based on changes in my coverage, including but not limited to, changes in benefits, payment obligations (such as deductible, coinsurance and copayments), my age, changes in tobacco user status, or other factors that require adjustments to the total premium. These changes may occur at times other than an annual or other policy renewal.

I further understand and agree that, if I have elected to authorize automatic premium withdrawals from a deposit account, the automatic withdrawal will change periodically to correspond with the applicable premium. My authorization for automatic premium withdrawals shall include authorization for automatic withdrawal of any changed amount unless I call or provide my bank with written notice not less than three (3) business days before a scheduled withdrawal to stop the payment. If I call my bank to stop payment, I may be required to provide a written request within fourteen (14) days after my call. I will be responsible for any fee assessed by my bank for stop-payment orders that I make.

Acknowledgement

I have read and understand the "Statements" and "Application Agreement and Certification" sections on this application. If I am replacing my current coverage, I have completed "Notice to Applicant Regarding Replacement of Medicare Supplement Insurance or Medicare Advantage." I hereby confirm the authority of Wellmark to make automatic withdrawals from my deposit account as set forth above under "Choose your method of payment" and that this authorization supersedes and replaces any previous authorization given by me with respect to such authority. I understand that any payment will be deposited immediately upon Wellmark's receipt of this application. I understand that Wellmark can change my premium at any time. If I am applying for coverage within 60 days of a premium change with an effective date prior to the premium change, Wellmark will provide notice of the new premium within a reasonable period of time after the enrollment of my application.

The information in this application is correct to the best of my knowledge. I understand that if I intentionally provide false information in this application, I will be disenrolled from the plan.

My signature is considered valid whether I supplied it online electronically, by telephone, or on paper and has the same full force and effect as my written signature.

☐ I give my permission to the licensed agent or agency who is identified with this application to enter my application online through **Wellmark.com.** (Agent is required to retain original paper application for 10 + 1 years.)

Applicant's Signature X_____ 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 _____/_____/_____

Applicant Name (First, Middle, Last)	Social Security Number

For Agent Only: List all health insurance policies you have sold to the applicant in the last five years, including those no longer in force.

Company	Policy Number	Type of Policy	In Force? (Y/N)

Agent Name (please print)_____ Agent Phone No. (_____) _____

Agent Signature_____ Date _____/_____/_____

Agent ID __ __ __ __ __ __ __ __ Farm Bureau Service Center Number (Bulk Mail Code)_____

Applicant's Farm Bureau Membership Number (if applicable)_____

Wellmark must receive the completed application within 15 days of the Applicant's signature date.

Send completed application to:

Wellmark Blue Cross and Blue Shield of Iowa
PO Box 14527, Mail Station 3W190
Des Moines, Iowa 50306-3527

Fax: 515-376-9045
E-mail: INDMEMMAIN@wellmark.com

Applicant Name (First, Middle, Last)	Social Security Number

Notice to Applicant Regarding Replacement of Medicare Supplement Insurance or Medicare Advantage

SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE.

According to your application, you intend to terminate existing Medicare supplement or Medicare Advantage insurance and replace it with a policy issued by Wellmark Blue Cross and Blue Shield of Iowa insurance company. Your new policy will provide thirty (30) days within which you may decide without cost whether you desire to keep the policy.

You should review this new coverage carefully. Compare it with all accident and sickness coverage you now have. If, after due consideration, you find that purchase of this Medicare supplement is a wise decision, you should terminate your present Medicare supplement or Medicare Advantage coverage. You should evaluate the need for other accident and sickness coverage you have that may duplicate this policy.

STATEMENT TO APPLICANT BY ISSUER OR ISSUER'S AGENT [BROKER OR OTHER REPRESENTATIVE]:
I have reviewed your current medical or health insurance coverage. To the best of my knowledge, this Medicare supplement policy will not duplicate your existing Medicare supplement or, if applicable, Medicare Advantage coverage because you intend to terminate your existing Medicare supplement coverage or leave your Medicare Advantage plan.

The replacement policy is being purchased for the following reason (you MUST check one):

☐ Additional benefits.
☐ No change in benefits, but lower premiums.
☐ Fewer benefits and lower premiums.
☐ My plan has outpatient prescription drug coverage and I am enrolling in Part D.
☐ Disenrollment from a Medicare Advantage plan. Please explain reason for disenrollment.

_____

_____

☐ Other (please specify): _____

1. **NOTE:** If the insurer of the Medicare supplement policy being applied for does not, or is otherwise prohibited from imposing preexisting condition limitations, please skip to statement 2 below. Health conditions which you may presently have (preexisting conditions) may not be immediately or 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 payable under your present policy.
2. State law provides that your replacement policy or certificate may not contain new preexisting conditions, waiting periods, elimination periods or probationary periods. The insurer will waive any time periods applicable to preexisting conditions, waiting periods, elimination periods, or probationary periods in the new policy (or coverage) for similar benefits to the extent such time was spent (depleted) under the original policy.
3. If you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical and health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy has never been in force. After the application has been completed and before you sign it, review it carefully to be certain that all information has been properly recorded.

Do not cancel your present policy until you have received your new policy and are sure that you want to keep it.

Signature of Agent, Broker, or Other Representative:_____

Applicant's Signature:_____

Date of Signatures: _____/_____/_____

Wellmark Blue Cross and Blue Shield of Iowa
PO Box 14527, Mail Station 3W190
Des Moines, Iowa 50306-3527

Required Federal Accessibility and Nondiscrimination Notice

Discrimination is against the law

Wellmark complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. Wellmark does not exclude people or treat them differently because of their race, color, national origin, age, disability or sex.

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

If you need these services, call 800-524-9242.

If you believe that Wellmark has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance with: Wellmark Civil Rights Coordinator, 1331 Grand Avenue, Station 5W189, Des Moines, IA 50309-2901, 515-376-4500, TTY 888-781-4262, Fax 515-376-9073, Email CRC@Wellmark.com. You can file a grievance in person, by mail, fax or email. If you need help filing a grievance, the Wellmark Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail, phone or fax at: U.S. Department of Health and Human Services, 200 Independence Avenue S.W., Room 509F, HHH Building, Washington DC 20201, 800-368-1019, 800-537-7697 (TDD).

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

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).

ສ່ຽງຄວນເອົາໃຈໃສ່, ພາສາລາວ ຖ້າທ່ານເວົ້າ: ພວກເຮົາມີບໍລິການຄວາມຊ່ວຍເຫຼືອດ້ານພາສາ ໃຫ້ທ່ານໂດຍບໍ່ເສຍຄ່າ 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).

တၢ်နုးသ့ဉ်ညါ–နမ့ၢ်ကတိၤကညီကျိာ်.ကျိာ်တၢ်မၤစၢၤတၢ်ဖံးတၢ်မၤတဖဉ်.လၢတဘဉ်လာ်ဘူးလဲ.ဆိဉ်လၢနဂီၢ်လီၤ.ဆဲးကျိုးဆူ ၈၀၀–၅၂၄–၉၂၄၂မ့တမ့ၢ်(TTY:၈၈၈–၇၈၁–၄၂၆၂)တက့ၢ်.

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 ወይም (በTTY: 888-781-4262) ይሙሉ ያነጋግሩን።

HEETINA To a wolwa Fulfulde laabi walliinde dow wolde, naa e njobdi, ene ngoodi ngam maaɗa. Heɓir 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)

09/16 A