



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.

# Employee Application for Health and Dental Insurance (for Non-ACA Groups)

Large Group  
Wellmark Blue Cross and Blue Shield of Iowa  
Fax: (515) 376-9047

Small Business and Mid-Size Groups  
Wellmark Blue Cross and Blue Shield of Iowa  
Fax: (515) 376-9042

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

Open Enrollment Period    Newly Eligible    Special Enrollee    Change

## A. Employer Information (Completed by Employer)

Group/Billing Unit No. \_\_\_\_\_ Department No. \_\_\_\_\_ Effective Date \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Employer Name \_\_\_\_\_ Phone Number (\_\_\_\_) \_\_\_\_\_  
 Employer Address Line 1 (Street Address or Suite#) \_\_\_\_\_  
 Employer Address Line 2 (PO Box, Street Address) \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

## B. Employee Information

Name (First, MI, Last) \_\_\_\_\_  
 Address Line 1 (Street Address or Apt/Suite#) \_\_\_\_\_  
 Address Line 2 (PO Box, Street Address) \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_  
 Home Phone Number (\_\_\_\_) \_\_\_\_\_ Work Phone Number (\_\_\_\_) \_\_\_\_\_ Ext. \_\_\_\_\_  
 Email Address (optional) \_\_\_\_\_  
 Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ (mm/dd/yyyy)   Gender:  Male  Female  
 Status  Single    Married    Common law    Domestic partner (Certification of Domestic Partnership form, M-4328, required)  
 Social Security Number/Tax Identification Number \_\_\_\_\_  
 (Social Security Number (SSN) or Tax Identification Number (TIN) must be provided.)  
 Date of Hire (required) \_\_\_\_/\_\_\_\_/\_\_\_\_ (mm/dd/yyyy)  
 Employment Status:  Full-Time    Part-Time    COBRA    Retiree    Seasonal  
 Health:  Employee    Employee/spouse or domestic partner  
            Employee/child(ren)    Employee/spouse or domestic partner/child(ren)  
 Health Plan Code: \_\_\_\_\_ Deductible Amount: \_\_\_\_\_  
 Dental:  Employee    Employee/spouse or domestic partner  
            Employee/child(ren)    Employee/spouse or domestic partner/child(ren)  
 Dental Plan Code: \_\_\_\_\_ Deductible Amount: \_\_\_\_\_

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 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.

## C. Waiver of Enrollment (Please complete if you are waiving health or dental 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.

I waive dental coverage for my dependents and myself. Please indicate one of the following reasons:  
 I (We) have coverage under another dental plan.  
 I (We) do not wish to enroll in the dental plan.

Please see the Section H. Important Information Regarding Waiver of Enrollment.

Employee Name (First, Last)	Social Security Number / Tax Identification Number
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**D. Enrollment Reason or Event**

**Special Enrollment Event Reason:**

<input type="checkbox"/> Birth	<input type="checkbox"/> Foster child placement
<input type="checkbox"/> Marriage/common law	<input type="checkbox"/> Involuntary loss of creditable coverage
<input type="checkbox"/> Divorce/dissolution of domestic partnership	<input type="checkbox"/> Permanent move to Iowa
<input type="checkbox"/> Adoption or placement for adoption	<input type="checkbox"/> Returning from military service
<input type="checkbox"/> Court-ordered coverage	<input type="checkbox"/> Domestic partnership
<input type="checkbox"/> Legal guardianship	<input type="checkbox"/> Other _____

List date of special enrollment event \_\_\_\_/\_\_\_\_/\_\_\_\_ (mm/dd/yyyy) (or last day of coverage)

**E. Members/Enrollees Covered** 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. Please confirm with your employer that the dependent types listed below are eligible.

List Name (First, MI, Last) of all others to be covered	Date of Birth	Social Security Number/Tax Identification Number <sup>1</sup>	Gender	FT Student? <sup>2</sup>	Disabled? <sup>2</sup>
Spouse or Domestic Partner	/ /	a. <input type="checkbox"/> SSN/TIN _____ b. <input type="checkbox"/> Does not have an SSN/TIN c. <input type="checkbox"/> I refuse to provide the SSN/TIN	<input type="checkbox"/> Male <input type="checkbox"/> Female	N/A	<input type="checkbox"/> Yes
Dependent	/ /	a. <input type="checkbox"/> SSN/TIN _____ b. <input type="checkbox"/> Does not have an SSN/TIN c. <input type="checkbox"/> I refuse to provide the SSN/TIN	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
Dependent	/ /	a. <input type="checkbox"/> SSN/TIN _____ b. <input type="checkbox"/> Does not have an SSN/TIN c. <input type="checkbox"/> I refuse to provide the SSN/TIN	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
Dependent	/ /	a. <input type="checkbox"/> SSN/TIN _____ b. <input type="checkbox"/> Does not have an SSN/TIN c. <input type="checkbox"/> I refuse to provide the SSN/TIN	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
Dependent	/ /	a. <input type="checkbox"/> SSN/TIN _____ b. <input type="checkbox"/> Does not have an SSN/TIN c. <input type="checkbox"/> I refuse to provide the SSN/TIN	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes

<sup>1</sup>The IRS requires Wellmark to collect SSNs/TINs for federal reporting purposes. Wellmark or your employer will follow up with you to collect this information if you do not complete a., b., or c. for each person listed. Failure to provide the SSN/TIN information may result in a \$50 penalty, per violation, assessed to you by the IRS.

<sup>2</sup>If your plan covers dependent(s) age 26 or older, they must be unmarried and either a full-time student or a disabled dependent. Please contact your Wellmark representative for more information.

Employee Name (First, Last)	Social Security Number / Tax Identification Number
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**F. Medicare Coverage (Required)**

Yes  No Are you and/or anyone listed in Section E Social Security disabled?  
 If yes, list names \_\_\_\_\_

Yes  No Are you and/or anyone listed in Section E enrolled in Medicare?  
 If yes, complete the following as appropriate:

Employee Name (as it appears on Medicare card)	Medicare ID
_____	_____

Effective Date (Part A)_____/_____/_____	Effective Date (Part B)_____/_____/_____
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Spouse or Domestic Partner Name (as it appears on Medicare card)	Medicare ID
_____	_____

Effective Date (Part A)_____/_____/_____	Effective Date (Part B)_____/_____/_____
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Dependent Name (as it appears on Medicare card)	Medicare ID
_____	_____

Effective Date (Part A)_____/_____/_____	Effective Date (Part B)_____/_____/_____
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**G. Other Carrier Information (Required)**

Yes  No Will you, your spouse or domestic partner, or your dependents keep other health coverage in addition to this Wellmark, Inc. coverage?

If yes, please complete the following:  
 Policyholder Name (First, Last)\_\_\_\_\_ Date of Birth\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Please list those covered by the other health plan(s)\_\_\_\_\_

Policy No.\_\_\_\_\_ Effective Date\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Employer Name (if coverage is through employer group)\_\_\_\_\_

Insurance Company/HMO Name\_\_\_\_\_

Address Line 1 (Street Address or Suite#)\_\_\_\_\_

Address Line 2 (PO Box, Street Address)\_\_\_\_\_

City\_\_\_\_\_ State\_\_\_\_\_ ZIP\_\_\_\_\_

Phone Number (if known) (\_\_\_\_\_)\_\_\_\_\_

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

**H. Important Information Regarding Waiver Enrollment**

If you are declining enrollment for yourself or your dependents (including your spouse or domestic partner) 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 a period of time specified by your Plan 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 the time specified by your Plan after the marriage, birth, adoption, or placement for adoption. Additionally, you must enroll within the time specified by your employer after you lose eligibility for coverage under Medicaid or CHIP or become eligible for Medicaid or CHIP premium assistance.

Employee Name (First, Last)	Social Security Number / Tax Identification Number
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**H. Important Information Regarding Waiver Enrollment, cont'd**

Please note that if you or your dependents are not covered by minimum essential coverage, you may be responsible for individual shared responsibility payments when filing your federal income tax return. Also, by declining the coverage offered by your employer, you or your dependents may not be eligible for Marketplace coverage subsidies.

To request special enrollment or obtain more information, refer to your Summary Plan Description (SPD), coverage manual, other benefit documents, or contact your employer.

**I. 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 and 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. I understand and grant authorization for my employer, group sponsor, consultant, or Wellmark agent to electronically submit the information provided by me on this signed application for enrollment purposes.

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

**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 that 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 taxpayer identification numbers to Wellmark for this purpose, I may be subject to a \$50 penalty per violation imposed by the Internal Revenue Service.

**HSA Coverage**

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.

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

**Employee Signature** \_\_\_\_\_ **Date** \_\_\_\_/\_\_\_\_/\_\_\_\_