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

Application for Blue Dental℠ and Avesis Vision & Hearing

Use this form to apply for Blue Dental and/or Avesis Silver Vision and Hearing. These plans are exclusively available for Wellmark Medicare supplement members. The earliest effective date of these plans will be the first of the month following the signature date on this form. The form may also be used to terminate your Medicare supplement plan, your Blue Dental or Avesis Silver Vision & Hearing plans. If you terminate your Medicare supplement plan your Blue Dental and Silver Vision & Hearing plans will also terminate.

REQUESTED EFFECTIVE DATE _____/_____/_____

Instructions: Use a ballpoint pen to complete the form and follow the guidelines listed below:

GUIDELINES				
Complete checked sections if you are using this form to:	**A**	**B**	**C**	**E**
Add Blue Dental plan	✓	✓		✓
Add Silver Vision & Hearing plan	✓	✓		✓
Change Blue Dental plan	✓	✓		✓
Change Silver Vision & Hearing plan	✓	✓		✓
Remove Blue Dental plan	✓		✓	✓
Remove Silver Vision & Hearing plan	✓		✓	✓
Terminate Medicare supplement and optional benefits	✓		✓	✓

A. EXISTING POLICYHOLDER INFORMATION

Existing Policyholder Name (First, Middle, Last)	Wellmark ID	
Physical Address *(Include Street, Bldg Name/No., Apt/Suite#)*	Telephone Number	
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/Suite#)*	PO Box	
City	State	ZIP

B. OPTIONAL BENEFITS

Please select **one** Blue Dental℠ plan. If you do not complete this section of the form, you will remain enrolled on your existing Blue Dental plan. ☐ Blue Dental℠ 100 ☐ Blue Dental℠ 75

Please select **one** Silver Vision & Hearing* plan. If you do not complete this section of the form, you will remain enrolled on your existing Silver Vision & Hearing plan. ☐ Silver Vision & Hearing 100 ☐ Silver Vision & Hearing 130

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" in Section D.

*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.

C. TERMINATION (if you terminate your Medicare supplement plan, it will terminate all benefits)

Termination date will be the first of the month following receipt of the request to terminate coverage.

- ☐ Terminate Blue Dental plan
- ☐ Terminate Silver Vision & Hearing plan
- ☐ Terminate both Blue Dental and Silver Vision & Hearing plans
- ☐ Terminate Medicare supplement plan including Blue Dental and/or Silver Vision & Hearing plan(s)

D. 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 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 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.

E. AUTHORIZATION, CERTIFICATION AND SIGNATURE

My signature is considered valid whether I supplied it by telephone or on paper and has the same full force and effect as my written signature.
I understand that by selecting Blue Dental or Avesis Silver Vision & Hearing products, and submitting this form I am electing to purchase an additional insurance product(s). I authorize Wellmark to collect premium for these products in addition to my Medicare supplement plan, including automatic EFT withdrawal from the same bank account which Wellmark has previously received authorization to debit.

Dental Exclusion 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 exclusion period will not be waived or reduced even if I have qualifying existing coverage or qualifying previous coverage.

Consent to receive Marketing Information and Solicitations Via Residential Telephone, Cellular Phone, Text and Email Messages
By checking the box later in this application and entering my signature on this application, I hereby provide my consent to Wellmark to contact me about Wellmark 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 services. I understand I may revoke this consent at any time by calling the number located on the back of my Wellmark ID card.

Consent to Electronic Delivery of Information
By checking the box later in this application and entering my signature on this application, I hereby provide my consent to Wellmark to deliver important notices and information about my health plan and coverage electronically. I understand I am being asked to consent to notices and documents being delivered to me electronically. My consent applies to notices and documents relating to my health insurance coverage ("Coverage") with Wellmark.

Right to Request for Paper Copies
I understand that I have the right to have a notice or document provided or made available in paper form at no cost. To obtain a paper copy of a notice or document delivered by electronic means or to withdraw consent, please contact Wellmark at (800) 336-0505.

E. AUTHORIZATION, CERTIFICATION AND SIGNATURE, cont'd

Right to Withdraw Consent

I understand that I have the right to withdraw consent to have a notice or document delivered by electronic means. Such consent will be deemed withdrawn upon receipt by Wellmark of the request to withdraw consent. Any withdrawal of consent shall not affect the legal effectiveness, acidity or enforceability a notice or document delivered by electronic means before the withdrawal of consent is effective. To withdrawal consent for electronic notice of documents please contact Wellmark at (800) 336-0505 or select "unsubscribe" option located within the email message.

Scope of Consent

This consent applies to all notices and documents relating to my Coverage, including, but not limited to:

- Explanation of Benefits;
- Disclosures and notices;
- Summary of Benefits and Coverage;
- Notices of cancellation, nonrenewal or termination;
- Benefits Policy, riders or endorsements;
- Responses to communications from you;
- Appeals correspondence;
- Billing and payment notices; and
- Other important information

Hardware and Software Requirements

In order to access, view and retain documents electronically, I understand I must have access to a personal computer or other device capable of accessing the internet with a web browser, email or web service capabilities, the ability to receive and review attachments to emails and software which permits me to receive and access Portable Document Format (PDF) files and MS Word files. Free software to view PDF files is available from: http://get.adobe.com/reader/. I confirm that I have access to the hardware and software necessary to receive and review electronic records and I have an active email account with the ability to receive and access emails and email attachments in the formats described.

NOTICE/DISCLAIMER

WELLMARK IS NOT RESPONSIBLE FOR ANY UNAUTHORIZED ACCESS BY THIRD PARTIES TO INFORMATION PROVIDED ELECTRONICALLY, INCLUDING, WITHOUT LIMITATION, ANY DIRECT, INDIRECT, SPECIAL, INCIDENTAL OR CONSEQUENTIAL DAMAGES RESULTING FROM SUCH UNAUTHORIZED ACCESS. WELLMARK ALSO IS NOT RESPONSIBLE FOR DELAYS IN TRANSMISSION OF NOTICES AND DOCUMENTS.

CONSENT

By accessing or opening the documents sent to me via the email address provided, I certify that (1) I consent and agree to receive notices and documents electronically and confirm that I will download or print them for my records; and (2) I have the ability to access the information that is provided electronically via email communications.

☐ I give my permission to the licensed agent/licensed agency who is identified with this application to enter my application on line through Wellmark.com.

☐ I authorize Wellmark to contact me via residential telephone, cellular phone, text and/or email for marketing purposes (**optional**).

☐ I consent to receive important information electronically (**optional**).

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 _____/_____/_____

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)_____

E. AUTHORIZATION, CERTIFICATION AND SIGNATURE, cont'd

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

Send completed form to:
Wellmark Blue Cross and Blue Shield of Iowa
Mail Station 3W190
PO Box 14527
Des Moines, IA 50309-3527

OR

Fax to: 515-376-9045

OR

Email to: updatesindividualmembership@wellmark.com

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